

FILED MAY 10 1956

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **13115**
Registrar's No. **1804**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 35 Yrs.		e. STREET ADDRESS (If rural, give location) Montrose Hotel, 40th & Main	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Pauline	b. (Middle) Alma	c. (Last) Armstrong	4. DATE OF DEATH (Month) (Day) (Year) Apr. 25, 1956
-------------------------------------	---------------------------	-------------------------	----------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 31, 1886	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	--	--	---	------------------------	----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kansas City Southern R. R.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Sarcoxié, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	-----------------------------------	--	--

13a. FATHER'S NAME James Armstrong	13b. MOTHER'S MAIDEN NAME Alma Schlein	14. NAME OF HUSBAND OR WIFE none
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 702-12-1030	17. INFORMANT'S SIGNATURE OR NAME V. V. Kirkpatrick ADDRESS Kansas City, Mo.
--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Competitive heart failure		2 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO Chronic Fibillation DUE TO Myocardial Damage		1 year 1 year 4 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **1-1-1956** to **4-25-56**, that I last saw the deceased alive on **4-25-56**, and that death occurred at **1:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE W. P. Miller (Degree or title) MD	23b. ADDRESS Boonville, Mo.	23c. DATE SIGNED 4-25-56
--	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-27-56	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
---	--------------------------	---	---

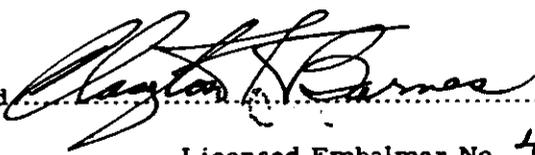
DATE REC'D BY LOCAL REG. 4-26-56	REGISTRAR'S SIGNATURE W. P. Miller	25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary ADDRESS K. C. Mo.
---	---	---

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 479

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.