

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35643  
STATE FILE NUMBER  
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4804

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospt.</b>		Length of stay in lb <b>14 Days</b>	d. STREET ADDRESS (If outside, give location) <b>1212 Harrison</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Maud Armstrong</b>			4. DATE OF DEATH Month Day Year <b>10-17-57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-92</b>
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Greentown, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Joshua Talley</b>	
13b. MOTHER'S MAIDEN NAME <b>Katie Clark</b>		14. NAME OF HUSBAND OR WIFE <b>Dont know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Forrest Hood, Sedalia, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism resulting from contusion of chest, fall and lead</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>from contusion of chest, fall</b> DUE TO (c) <b>and lead</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>E983X</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>apparently beaten by</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>10-3-57</b>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Kansas City Jackson Mo</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
21. SIGNATURE (Degree as title) <b>Geo. C. Kealhofer</b>		22b. ADDRESS <b>6627 Pecan Ridge Ave</b>	22c. DATE SIGNED <b>10-17-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-19-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greentown Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Greentown, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ralph O, Jones, Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-18-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

Geo. C. Kealhofer, Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Jack T. Moore* .....

Licensed Embalmer No. *4729* .....

P. O. Address *Sumner* .....

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!-01-01  
If this body is not embalmed, fact should be so stated above.

