

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004107

STATE FILE NUMBER

FILED FEB 6 1959

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) Sikeston		c. CITY OR TOWN Charleston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hosp.		d. STREET ADDRESS (If outside, give location) Route #1	
3. NAME OF DECEASED (Type or print) First SANDRA Middle DALE Last ARMSTRONG		4. DATE OF DEATH Month 1 Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 0		11. BIRTHPLACE (City and state or country) Mississippi Co., Missouri	
13a. FATHER'S NAME Nathaniel Armstrong		14. NAME OF HUSBAND OR WIFE 0	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO. 0	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 493		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 493	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1/20/59		20f. CITY, TOWN, OR LOCATION Charleston, Mo.	
21. I attended the deceased from Death occurred on 1/20/59 at 5 P. and last saw her alive on 1/20/59 m on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 1/24/59	
22a. SIGNATURE L. R. Sparks (Degree or title)		22b. ADDRESS Charleston, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 22, 1959	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) Charleston, Mo.	
24. FUNERAL DIRECTOR L. R. Sparks ADDRESS Charleston, Mo.		25. DATE RECD. BY LOCAL REG. 1-26-59	
26. REGISTRAR'S SIGNATURE Mrs. E. H. Hunter			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coronar, etc. must use only standard nomenclature in item 10. NO symptoms must be stated. All diseases in Part I must be causally related.

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 *Eddie Middleton*

Licensed Embalmer No. *5046*

P.O. Address.
Cape Girardeau, 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.