

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028542**

**FILED VS AUG 26 1959**

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 4149 22-1959 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>COBA</u>		Length of stay in 1b <u>10 DAYS</u>	c. CITY OR TOWN <u>SULLIVAN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SENIOR CITIZENS HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. R. 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>J. L.</u> Last <u>ARMISTEAD</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1893</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>FRANKLIN Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>THOMAS J. ARMISTEAD</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH BANDY</u>		14. NAME OF HUSBAND OR WIFE <u>MAUDE ELLEN SORREKS</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/A</u>	16. SOCIAL SECURITY NO. <u>486-14-3334</u>	17. INFORMANT <u>THOMAS ARMISTEAD, ST. LOUIS, MO.</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Urinary failure</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Carcinoma</u>	<u>unknown</u>
	DUE TO (c) <u>Carcinoma of stomach</u>	<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>Aug 17, 1959</u> to <u>Aug 20, 1959</u> and last saw her/him alive on <u>17 Aug 59</u> Death occurred at <u>11:30</u> <u>p</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Ronald Van Orsdel, M.D.</u> (Degree or title)		22b. ADDRESS <u>Bourbon, Mo.</u>		22c. DATE SIGNED <u>21 Aug 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN BAPTIST CH. CEM.</u>	23d. LOCATION (City, town, or county) <u>HESLIE, MO</u>	(State)
24. FUNERAL DIRECTOR <u>H. M. EATON SULLIVAN, MO</u>		25. DATE RECD. BY LOCAL REG. <u>8-21-1959</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis W. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, W.

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.