

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032196

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4643 STATE FILE NUMBER

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|---|----------------------------------|---|--|--|---|
| 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, give TOWNSHIP only) OR TOWN KANSAS CITY | | Length of stay in 1b 14 days | c. CITY OR TOWN RAYTOWN | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 8900 EAST 74TH | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle B Last ARMSTRONG | | | 4. DATE OF DEATH Month September Day 21 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-3-15 | 9. AGE (last birthday) 44 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist | | 10b. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (City and state or country) Pittsburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Robert B. Armstrong | | 13b. MOTHER'S MAIDEN NAME Jane Lennox | | 14. NAME OF HUSBAND OR WIFE Mary Armstrong | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT VA Hospital Official Records, K.C. Mo. | |

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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) Esophageal hemorrhage | | | |
| DUE TO (b) Esophageal varicosities | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Laemec's cirrhosis | | | |
| 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 |

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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year | | | |

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|---|--|--|----------------------|---------------------|
| 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 RAYTOWN | COUNTY MO. | STATE MO. |
| 21. Attended the deceased from September 7, 1959 to September 21, 1959 Death occurred at 3:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|--|-----------------------------------|--|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, MD | | 22b. ADDRESS VA Hospital, Kansas City, Mo. | | 22c. DATE SIGNED 9-22-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE Sept 24, 1959 | 23c. NAME OF CEMETERY OR CREMATORY BROOKING Cem. | 23d. LOCATION (City, town, or county) (State) RAYTOWN, MO. | |
| 24. FUNERAL DIRECTOR Kepley Hinton | ADDRESS RAYTOWN, Mo. | 25. DATE RECD. BY LOCAL REG. 9-24-59 | 26. REGISTRAR'S SIGNATURE neva minshall | |

(Licensed Embalmer's Statement on Reverse Side)

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 John R. Didd

Licensed Embalmer No. 453

P. O. Address Kansas

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.