

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000262

FILED VS JAN 18 1960

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STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in 1b <u>most of life</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.R.#2 No.2nd Street Road</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>GREEN</u> Last <u>ARMSTRONG</u> | | | 4. DATE OF DEATH Month <u>January</u> , Day <u>8</u> , Year <u>1960</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>4/7/1888</u> | 9. AGE (last birthday) <u>71 years</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stationary Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Western Grocery</u> | 11. BIRTHPLACE (City and state or country) <u>Tangipahoa, La.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Armstrong</u> | | 13b. MOTHER'S MAIDEN NAME <u>Barbara Rohner</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mrs. Opal L. Armstrong</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>491-10-2147</u> | 17. INFORMANT <u>Mrs. Opal L. Armstrong, St. Joseph, Mo.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>at once</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 _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <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.) | | 20f. CITY, TOWN, OR LOCATION _____ | | COUNTY _____ | STATE _____ |
| 21. I attended the deceased from <u>9/17/59</u> to <u>1/8/60</u> and last saw ^X her him alive on <u>1/8/60</u> Death occurred at <u>8:55 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Samuel Meloney M.D.</u> | | | 22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u> | | 22c. DATE SIGNED <u>1/9/60</u> |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1/11/1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Joseph, Missouri</u> | (State) _____ |
| 24. FUNERAL DIRECTOR <u>Stoney Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Jan. 12, 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> | | |

DOCUMENT

S.E. Meloney, M.D. 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 Earna Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.