URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-028064

FILED VS AUG 1 2 1960

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Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7645 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Faith Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 8108 Pennsylvania
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Mamie Middle: G. Last: Armstrong
4. DATE OF DEATH: Month: August Day: 2 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/18/1902
9. AGE (last birthday): 58
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): St. Clair, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Halley
13b. MOTHER'S MAIDEN NAME: Lydia Arnold Halley
14. NAME OF HUSBAND OR WIFE: Scott Armstrong
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Scott Armstrong Address: 8108 Pennsylvania

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7/22/60
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Auricular fibrillation.
DUE TO (c): 433.1 & Cardio-vascular disease — ?
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7/27/60, to 8/2/60 and last saw her alive on 8/2/60.
Death occurred at 4:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. J. Signorelli (Degree or title) M.D.
22b. ADDRESS: 3400 N. Kingshighway
22c. DATE SIGNED: 8-2-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 5, 1960
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.
24. FUNERAL DIRECTOR: C. Hoffmeister Mortuaries ADDRESS: 7834 So. Broadway St. Louis, Mo.
25. DATE RECD. BY LOCAL REG.: AUG 3 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. M.S.B.

(Licensed Embalmer's Statement on Reverse Side)

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 Louis C. Hoffman

Licensed Embalmer No. 3871

P. O. Address 7814 S. B

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.