

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034575

FILED VS OCT 3 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 135

STATE FILE NUMBER

|                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                  |                                                   |                                                                                                                                                                                 |                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Howe</u>                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                              | 2. USUAL RESIDENCE (Where deceased lived in institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Howe</u> |                                                   |                                                                                                                                                                                 |                                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>West Plains</u>                                                                                                                                                                                                                                                            |                                                                                                           | Length of stay in lb<br><u>2 wks</u>                                                                                                                        |                                                                                              | c. CITY OR TOWN <u>West Plains</u>                                                                                               |                                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                            |                                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><u>Memorial Hosp.</u>                                                                                                                                                                                                                                                               |                                                                                                           | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                   |                                                                                              | d. STREET ADDRESS (If outside, give location)<br><u>828 N. Main St</u>                                                           |                                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                           |                                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Jessie Irene</u> Middle <u>Ann</u> Last <u>Armstrong</u>                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                                              | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>18</u> Year <u>60</u>                                                                  |                                                   |                                                                                                                                                                                 |                                                  |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE <u>W</u>                                                                                 | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-1-19</u>                                                            | 9. AGE (last birthday)<br><u>69</u>                                                                                              | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>17</u> |                                                                                                                                                                                 | IF UNDER 24 HR<br>Hours <u>10</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                            |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>                                                                                                            |                                                                                              | 11. BIRTHPLACE (City and state or country)<br><u>West Plains Mo</u>                                                              |                                                   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>                                                                                                                                       |                                                  |
| 13a. FATHER'S NAME<br><u>W. J. Sweeney</u>                                                                                                                                                                                                                                                                                                 |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><u>Neta Helen</u>                                                                                                              |                                                                                              | 14. NAME OF HUSBAND OR WIFE<br><u>L. E. Armstrong</u>                                                                            |                                                   |                                                                                                                                                                                 |                                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                      |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>No</u>                                                                                                                        |                                                                                              | 17. INFORMANT<br><u>L. E. Armstrong</u> Address <u>West Plains Mo</u>                                                            |                                                   |                                                                                                                                                                                 |                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Papillary adenocarcinoma right ovary with multiple metastasis</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                  |                                                   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 or 5 months</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                                  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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>9/3/60</u> to <u>9/18/60</u> and last saw her alive on <u>9/18/60</u><br>Death occurred at <u>7:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                              |                                                                                                                                  |                                                   |                                                                                                                                                                                 |                                                  |
| 22a. SIGNATURE (Degree or title)<br><u>C. C. Galligan M.D.</u>                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                                              | 22b. ADDRESS<br><u>West Plains, Missouri</u>                                                                                     |                                                   | 22c. DATE SIGNED<br><u>9/23/60</u>                                                                                                                                              |                                                  |
| 23a. BURIAL, CREMATION, OR DISPOSITION (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                          |                                                                                                           | 23b. DATE<br><u>9-29-60</u>                                                                                                                                 |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><u>East Lawn</u>                                                                           |                                                   | 23d. LOCATION (City, town, or county) (State)<br><u>West Plains Mo</u>                                                                                                          |                                                  |
| 24. FUNERAL DIRECTOR<br><u>Robertson</u>                                                                                                                                                                                                                                                                                                   |                                                                                                           | ADDRESS<br><u>West Plains Mo</u>                                                                                                                            |                                                                                              | 25. DATE RECD. BY LOCAL REG.<br><u>9-29-60</u>                                                                                   |                                                   | 26. REGISTRAR'S SIGNATURE<br><u>Beatrice Cook</u>                                                                                                                               |                                                  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

KS  
AUG 23 1961

OCT 26 1961

KS  
MAY 3 1961

### 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 L. A. Roach

Licensed Embalmer No. 343  
P. O. Address Hearts

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.