

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 10 1960

318

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10642

-60-039491

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2515 Belle Glade</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2515 Belle Glade</u>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>Armstrong</u> Last			4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1909</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
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>Harris Sheet Metal</u>	11. BIRTHPLACE (City and state or country) <u>England, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Armstrong</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Bolden</u>		14. NAME OF HUSBAND OR WIFE _____	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>430-40-2849</u>	17. INFORMANT <u>Beatrice Titus</u>	Address <u>2515 Belle Glade</u>
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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: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>
DUE TO (b) <u>Paralysis</u>		
DUE TO (c) <u>443x</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>10/1/60</u> to <u>10/31/60</u> and last saw him alive on <u>10/31/60</u> . Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Orville C. Taylor, M.D.</u> (Degree or title)	22b. ADDRESS <u>1423 No Grand</u>	22c. DATE SIGNED <u>11/1/60</u>
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <u>November 5, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>
		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u> (State)

24. FUNERAL DIRECTOR <u>John Wright</u> <u>Norside Mortuary</u>	ADDRESS <u>2410 N. Grand</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 3 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Leroy H. Penn

Licensed Embalmer No. 45

P. O. Address 4251 96

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