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| Registration District No. <u>351</u> | | Primary Registration District No. <u>4515</u> | | Registrar's No. <u>72</u> | | STATE FILE NUMBER | |
| AMENDED | | | | | | | |
| FILED AUG 14 1961 | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Sullivan</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u> | | Length of stay in 1b <u>2 days</u> | | c. CITY OR TOWN <u>Raytown</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S.C.M. Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>8812 E 84th St</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>INA RUTH ARMSTRONG</u> | | | | 4. DATE OF DEATH Month Day Year <u>8 - 9 - 1961</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-1-1896</u> | |
| 9. AGE (last birthday) <u>66</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (City and state or country) <u>Brunswick Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Benjamin S. Leake</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Maggard</u> | | 14. NAME OF HUSBAND OR WIFE <u>Denzel Armstrong</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>526-01-1655</u> | | 17. INFORMANT <u>Mo Jack White Raytown Mo</u> | | Address | |
| 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>Paralysis of Lungs (failure to breathe) to Hypostatic</u> DUE TO (b) <u>Loss of use of bladder + bowels (paralysis)</u> DUE TO (c) <u>Paralysis due to Spinal Cord Lesion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 months</u> <u>18 months ago</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 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>February 1961</u> to <u>August 1961</u> and last saw her alive on <u>August 8-1961</u> Death occurred at <u>August 9 1961 8: a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Reta W. Eitel D.O.</u> | | | | 22b. ADDRESS <u>Salt Mission</u> | | 22c. DATE SIGNED <u>8/9/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8-11-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Salt Cem.</u> | | 23d. LOCATION (City, town, or county) <u>Salt Mo</u> | |
| 24. FUNERAL DIRECTOR <u>Rayne Funeral Home</u> | | ADDRESS <u>Salt Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-11-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u> | |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed P. K. Payne Jr.

Licensed Embalmer No. 3400

P. O. Address Salt

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.