

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025737

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 381
Primary Registration District No. 4515 Registrar's No. 53
FILED JUN 25 1962

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

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>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>20 min.</u>	
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 <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY A. ARMSTRONG</u>		4. DATE OF DEATH Month Day Year <u>6 - 19 - 1962</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>6-28-1883</u>
9. AGE (last birthday) <u>78</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>Homemaking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sowa</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Leshbaugh</u>		13b. MOTHER'S MARDEN NAME <u>Phoebe Farthing</u>	
14. NAME OF HUSBAND OR WIFE <u>Edward 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>✓</u>		17. INFORMANT <u>Nellie Armstrong, Osgood 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>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</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 checked="" 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.) <u>Osgood, Sullivan Mo</u>		20f. CITY, TOWN, OR LOCATION <u>Osgood, Sullivan Mo</u>	
21. I attended the deceased from <u>Jan 1958</u> to <u>Jan 1962</u> and last saw her alive on <u>Jan 1962</u> Death occurred at <u>3:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John S. Maguire M.D.</u> (Degree or title)		22b. ADDRESS <u>W. Fair Mo</u>	
22c. DATE SIGNED <u>6/18/62</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-21-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Osgood Mo</u>
24. FUNERAL DIRECTOR <u>Payne Funeral Home Salt Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-21-62</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 PK Payne J

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.