

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

12001

PLACE OF DEATH

County Cass

Registration District No. 157

File No. _____

Township _____

Primary Registration District No. 7091

Registered No. _____

City Pleasant Hill No. _____

St. _____ Ward _____

2. FULL NAME Cara B. West

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 26/1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 9 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

10. NAME OF FATHER Elias West

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Laurie Hocker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

14. INFORMANT Mrs. Delaride Haleden (Address) Pleasant Hill Mo

15. FILED Apr 29, 1930 W. J. Veira, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 - 1930

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 9, 1930, that I last saw him alive on April 9, 1930, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Stroke Paralysis

82A

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) none

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) C. L. Carroll M. D.

, 19 1930 (Address) Pleasant Hill Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pleasant Hill

DATE OF BURIAL April 10 1930

20. UNDERTAKER W. W. Horn

ADDRESS Pleasant Hill

