

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 13 1934

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

Do not use this space.

36154
4657

1. PLACE OF DEATH

County JACKSON Registration District No. _____
Township KAW Primary Registration District No. _____
City KANSAS CITY (No. ST. LUNE'S HOSPITAL) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME BURTON NEAL WEST

(a) Residence, No. 3000 EAST LINWOOD BLVD. Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 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) JULY 4-1934

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>0</u>	<u>3</u>	<u>15</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) KANSAS CITY
(STATE OR COUNTRY) MISSOURI

13. NAME B. M. WEST

14. BIRTHPLACE (CITY OR TOWN) OMAHA
(STATE OR COUNTRY) NEBRASKA

15. MAIDEN NAME IRENE C. SUBLETT

16. BIRTHPLACE (CITY OR TOWN) KANSAS CITY
(STATE OR COUNTRY) KANSAS

17. INFORMANT MR. B. M. WEST
(ADDRESS) 3000 EAST LINWOOD BLVD.

18. BURIAL, CREMATION, OR REMOVAL PLACE FOREST HILL DATE OCT-22 1934

19. UNDERTAKER D.W. NEWCOMER'S SONS
(ADDRESS) 2111 EAST 9TH ST.

20. FILED 10-20 1934 9 AM Crowe
asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCT-19 1934

22. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1934, to Oct 19, 1934.

I last saw him alive on Oct 19, 1934. Death is said to have occurred on the date stated above, at 1:50 P.M.

The principal cause of death and related causes of importance were as follows:

Intestinal obstruction (adhesions)

Date of onset

10
18
34

Other contributory causes of importance: None

Name of operation Inte up adhesion Date of 10-19-34

What test confirmed diagnosis? None Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1934

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify no (Signed) H L Sawyer, M. D.

(Address) 406 W. 34

914 Medical Arts Bldg.

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