

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.

REC'D OCT 12 1938

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

30459  
Do not use this space.

1. PLACE OF DEATH  
 (a) County ..... Registration District No. 791  
 (b) Township ..... Primary Registration District No. 1003  
 (c) City St. Louis (d) Street No. 3109 Dr. Taylor ave St. 230  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN-H. WEST  
 (a) Residence, No. 3109 Dr. Taylor ave St. 10  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Leona West

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB-2-1872

7. AGE YEARS 66 MONTHS 7 DAYS 2 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter  
 9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) St. Louis 0

FATHER  
 13. NAME John West 1  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill 1

MOTHER  
 15. MAIDEN NAME Leona Kruger  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boston - Mass

17. INFORMANT (ADDRESS) Ann Leona West 3109 Dr. Taylor

18. BURIAL, CREMATION, OR REMOVAL PLACE Laurel Hills DATE Sept. 7 1938

19. FUNERAL DIRECTOR (ADDRESS) Edw. F. Woodward & Son 4212 St. Louis ave

20. FILED SEP-6-1938 J. D. Bueker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4 1938

22. I HEREBY CERTIFY, That I attended deceased from July 6 1938 to Sept 4 1938. I last saw him alive on September 4 1938. Death is said to have occurred on the date stated above, at 9:30 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis Date of onset -?  
Aortic Aneurism -?

Other contributory causes of importance:  
None

Name of operation ..... Date of .....  
 What test confirmed diagnosis? Phys Exam 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 ..... 19.....  
 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? no  
 If so, specify John B. M. Turner M. D.  
 (Signed) John B. M. Turner  
 (Address) 5014 Thekla av.

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No.....or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Edw. F. Howard*  
Licensed Embalmer No. *1443*

**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.)**