

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4072**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Jackson**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **K.C. General Hosp**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 days**
(Specify whether)

In this community **20 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **830 W 39th**
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **James H. West**

3. (b) If veteran name war **No**

3. (c) Social Security No. **None**

20. DATE OF DEATH: Month **10** day **22**
year **1939** hour **7** minute **10** A.M.

4. Sex **Male**

5. Color or race **Wh**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Mary E. West**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 3 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10-11**
1939 to **10-22**, 1939;
that I last saw him alive on **10-22**, 1939;
and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **4** Days **19**
If less than one day _____ hr. _____ min.

Immediate cause of death **Hypostatic congestion of lungs**

Due to **Myocardial Insufficiency**

Due to **Generalized Arteriosclerosis**

9. Birthplace **Middleton Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Minister**

Other conditions (includes pregnancy within 3 months of death) **93d?**

Major findings: Of operations _____

11. Industry or business **9**

MOTHER FATHER { 12. Name **Joe West**

13. Birthplace **Nashville Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **No record**

15. Birthplace **" "**
(City, town, or county) (State or foreign country)

Of autopsy **See above**

22. If death was due to external causes, fill in the following:

16. (a) Informant's own signature **General Hospital**

(b) Address **Records**

17. (a) **Cremation** (b) Date thereof **Oct. 24, 39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cem.**

18. (a) Signature of funeral director **John W. Wagner**

(b) Address **R.C.M.O.**

19. (a) **10/23/39** (b) **M.M. Brown**
(Date received local registrar) (Registrar's signature)

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **P. J. de Maria** (Full name or other) _____

Address **K.C. Gen Hosp** Date signed **10-23-39**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.