

JUN 1 1940

Registration District No. 752

Primary Registration District No. 599

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Ripley
 (b) City or town Rural
 (c) Name of hospital or institution
Pine Township 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Jimmie M. West 230

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Sept 15th 1939
(Month) (Day) (Year)8. AGE: Years _____ Months 7 Days 18 If less than one day _____ hr. _____ min.9. Birthplace Briar Mo
(City, town, or county) (State or foreign country)10. Usual occupation Learned Infant 0

11. Industry or business _____

12. Name Delmer Otto West 013. Birthplace Briar Mo
(City, town, or county) (State or foreign country)14. Maiden name Tha Tharp West15. Birthplace Briar Mo
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Delmer O. West(b) Address Briar Mo17. (a) Burial (b) Date thereof 4-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oak Ridge18. (a) Signature of funeral director H. Jordan(b) Address Douglas Mo.19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ripley
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Pine Township
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 28
year 1940 hour 2:00 minute 4 M.21. I hereby certify that I attended the deceased from 4/26/40
_____, 19____, to 4/28/40, 19____that I last saw him alive on 4/28/40, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Lobar Pneumonia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(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? _____

676 _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Clifford Hofort (M. D. or other) _____

Address _____ Date signed _____

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11 11

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19360

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 752

Primary Registration District No. 5993

Registrar's No. 20

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

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Pinetop
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Jessamine M. West

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race wh 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months 7 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-10-40 (b) G. G. Seragur (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month 4 day 28 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(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) _____ Means of injury _____

23. Signature Clifford P. Parfitt (or other) _____
Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-19360