

No. 1-1  
X21492

FILED JUL 15 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22161

Registration District No. 420

Primary Registration District No. 5633

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Lawrence RURAL  
(b) City or town Mt. Vernon Turners Fork T.P.  
(c) Name of hospital or institution: 2

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

In this community years, months or days 230

3. (a) PRINT FULL NAME JAMES FRANKLIN WEST

3. (b) If veteran, name war X X 3. (c) Social Security No. 293-14-1933

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Clara A West 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased JUNE 12 1872 (Month) (Day) (Year)

8. AGE: Years 68 Months 13 If less than one day hr. min.

9. Birthplace LAWRENCE CO MO (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

12. Name A. T. WEST

18. Birthplace TENN (City, town, or county) (State or foreign country)

14. Maiden name SARAH COLLINS

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

16. (a) Informant Mrs Clara A West

(b) Address Mt Vernon

17. (a) Burial (b) Date thereof JUNE 16, 40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation JOHN CHAPEL CEM

18. (a) Signature of funeral director A. S. Wallace

(b) Address Billings

19. (a) 6-15-1946 (b) O. D. Holmes (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LAWRENCE

(c) City or town MT. VERNON RURAL (If outside city or town limits write "RURAL")

(d) Street No. N.E. MT VERNON 12 MILES (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 13 year 40 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from May 12 1940 to June 6 1940 that I last saw him alive on June 6 1940 and that death occurred on the date and hour stated above.

Immediate cause of death carcinoma of gall bladder + liver

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: carcinoma of gall bladder + liver tissues

Of operations

Of autopsy

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

23. Signature S. C. Roper (M. D. or other) 1

Address Springfield Date signed 6-14-40

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

RECEIVED

District Health Officer No. 6,

District File Number 740-2324

Date Filed JUL 9 1910

46

**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 me

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

Signed Everett R. Head

Licensed Embalmer No. 4038

P. O. Address Billings, Mo.

**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. 22161

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 470

Primary Registration District No. 3640

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Turnbourn T. P.  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME James Franklin West

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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

8. AGE: Years 68 Months - 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 \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 13 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of gall bladder and liver originating in gall bladder

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 46

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) (e) Means of injury \_\_\_\_\_

23. Signature E. C. Roseberry (M. D. or other) \_\_\_\_\_

Address Springfield mo Date signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

ROWENH MOORE

