

S. No. 2
-1-4-41
5-17-39
-1 X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10533

State File No. _____

APR 21 1941

Registration District No. 25-8

Primary Registration District No. 5860A

Registrar's No. ~~1~~ 2

1. PLACE OF DEATH

(a) County DeKalb
(b) City or town Rural North Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stewartsville, Mo. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 Month 27 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb 32
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 2 mi North East of Clarkdale (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cecil Philip West

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 Feb 4 1941 (Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Cecil A West

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

14. Maiden name Ruby Schneider

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

16. (a) Informant Quentin Marks
(b) Address Stewartsville Mo

17. (a) Burial (b) Date thereof April 8 1941 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director John H. ...
(b) Address Stewartsville
19. (a) 4-1-1941 (Date received local registrar) (b) Mrs. C. H. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31 year 1941 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Mar 31 1941 to Mar 31 1941; that I last saw him alive on Mar 30 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Malformation Heart
Due to Blue Baby

Due to _____
Other conditions (Include pregnancy within 3 months of death) 1576

Major findings: Of operations _____ Of autopsy NO

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? _____
(Specify type of place) _____ (e) Means of injury _____
23. Signature E. M. Reynolds (M. D. or other) _____
Address Union Stor Mo Date signed 4-7-41

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

32
0
0

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.....

F. G. Lopez

Licensed Embalmer No. *957*

P. O. Address.....

Stewartville 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, fact should be so stated above.