

Registration District No. 85 Primary Registration District No. 1001

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town St Joseph
(c) Name of hospital or institution: St Joseph Hospital
(d) Length of stay: one week
In this community one week

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Daviess
(c) City or town Winston
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME ADDIE WEST
(b) If veteran, name war _____ (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4-7- year 1941
#1. I hereby certify that I attended the deceased from 4-8-41 to 4-7- 1941.

4. Sex F 5. Color or race W
6. (b) Name of husband or wife Robert West
7. Birth date of deceased Aug 2 - 1882

that I last saw her alive on 4-7- 1941
and that death occurred on the date and hour stated above.
Immediate cause of death Pulmonary edema Duration 4 days

8. AGE: Years 58 Months 8 Days 5 If less than one day _____ hr. _____ min.

Due to Peritonitis + Nephritis
Due to Septicemia

9. Birthplace South County Kansas
10. Usual occupation House Wife

Other conditions (include pregnancy within 3 months of death) _____

11. Industry or business _____
12. Name Frank Curtis
18. Birthplace Mo

Major findings: Of operations no operation
Of autopsy none
Underline the cause to which death should be charged statistically.

14. Maiden name Harriet Shivers
15. Birthplace Missouri

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant's own signature _____
(b) Address Winston Mo
17. (a) Heard (b) Date thereof April 7 - 41
(c) Place: burial or cremation Winston
18. (a) Signature of funeral director Robt. Thompson
(b) Address Winston Mo
19. (a) 4-7-1941 (b) A. J. Nestlerugh

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Paul Forgave (M. D. or M.D.)
Address St Joseph Mo Date signed 4-7-41

731 Faraon St.

WHILE FILLING IN THIS FORM, 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.

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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. 13925
Registrar's No. 399

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(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)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Addie West

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced w
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 58 Months 8 Days 5- 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 7
year 1941 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 day and hour stated above.

Immediate cause of death Pulmonary Edema Duration _____

peritonitis + nephritis

Due to Salpingitis - non venereal + non puerperal

Other conditions (Include pregnancy within 3 months of death)

Major findings: Secondary to oed

Of operations Chronic leucocytosis

Of autopsy Paul Jorgensen

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-13925

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