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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23234

Filed AUG 6 1942 791

Registration District No. ..... Primary Registration District No. 1003

Registrar's No. 6275

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Hospt. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County St. Louis 19

(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")

(d) Street No. 4134 Maryland
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country O

3. (a) PRINT FULL NAME Leora West

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Rickey mWest

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased June (Month) 27 (Day) 1906 (Year)

8. AGE: Years 36 | Months 0 | Days 26 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Holland Stith
13. Birthplace Keatsville, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Margaret Stutiville
15. Birthplace Blue Mound, (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Rickey West
(b) Address 4134 Marvland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/42 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Ave.

19. (a) JUL 24 1942 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from 7/22 1942 to 7/23 1942
that I last saw her alive on 7/23 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Subdural hemmorhage — Duration 2 days

Due to Ruptured blood vessel

Due to .....

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy Not done

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

23. Signature L. E. Gratiot (M. D. or other)
Address 4500 Olive St. Date signed 7/24/42

844 (Licensed Embalmer's Statement on Reverse Side)

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 J. G. Sullivan

Licensed Embalmer No. 11-22

P. O. Address 4700 Washington

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.