

ED AUG 11 1943

State File No.....

3303

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.....

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: 2 months - 10 days
(Specify whether in this community 2 months - 10 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rt. #2
(If rural, give location)

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

3. (a) PRINT FULL NAME Betty June West

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1943 hour 9:30 P.M. minute M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov. 28 1931
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____; and that death occurred on the _____ date at _____ hour stated above.

Immediate cause of death: Post Mortem

Diffuse rheumatic pericarditis with adhering pericarditis, dilatation, hypertrophy, mitral & tricuspid.

Dilatation & regurgitation

Diffuse bronchopneumonia

Osteomyelitis of the mandible

Chronic passive congestion

Chronic passive congestion of the liver

Chronic passive congestion of the viscera

Duration _____

8. AGE: Years Months Days If less than one day

11 7 28 hr. min.

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

10. Usual occupation at school

11. Industry or business _____

12. Name Roy E. West

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

14. Maiden name Ebene West

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

16. (a) Informant Roy E. West

(b) Address Rt 2 Indep. Mo.

17. (a) Funeral (b) Date thereof 7/29/43
(Funeral, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem.

18. (a) Signature of funeral director Geo. C. Carson

(b) Address Independence, Mo.

19. (a) 7-29-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

Physician _____

Underline the cause or causes of death which should be charged statistically.

22. If death was due to external causes, any of 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) _____ (Specify means of injury)

23. Signature John H. Griffin M.D.
Address Merwin Childrens Hosp Date signed 7-29-43

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

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. 2467

P. O. Address. Indep. 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.