S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1943 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33648

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 9569

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

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:
Lutheran Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 5202a Louisiana
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna West

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Berry West 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 5, 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Richaland (City, town, or county) Missouri (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

FATHER
12. Name West
13. Birthplace Not known (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) Not known (State or foreign country)

16. (a) Informant Max West
(b) Address 5202a Louisiana

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/3/43 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director J L Ziegenhein & Sons
(b) Address 7027 Gravois

19. (a) NOV 1 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1943 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from Oct 23 1943, to Oct 30 1943
that I last saw her alive on Oct 30 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremic Poisoning	3 days
Due to: Chronic Hypertension	2 yrs
Due to: Chronic cardiac, myocarditis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 A. M. Grant (M. D. or other)
Address 3651 Grandview Date signed Nov 1 43

(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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.