

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 224

Registration District No. 4

Primary Registration District No. 2007

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

1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Poplar Bluff, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Brandon  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution day 9 1/2  
 (Specify whether  
 In this community Life  
 years, months or days)

3. (a) PRINT FULL NAME MARKLESS WEST  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

4. Sex mo 5. Color or race w  
 6. (a) Single, widowed, married, divorced, married  
 6. (b) Name of husband or wife Nellie West  
 6. (c) Age of husband or wife if alive 60 years  
 7. Birth date of deceased Nov 16 1872  
 (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 22  
 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Thomas West

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

14. Maiden name Adeline Jackson

15. Birthplace Madison Co - Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant T. West

(b) Address unknown, Mo.

17. (a) Buried (b) Date thereof July 9 - 44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beulah Cemetery

18. (a) Signature of funeral director Webb - Holt Funeral Home

(b) Address Fredericktown, Mo.

19. (a) 7-14-44 (b) Belle Kinne  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Madison  
 (c) City or town Poplar - Jewett, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country? L (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
 year 1944 hour 10 minute 52 A.M.

21. I hereby certify that I attended the deceased from July 6, 1944, to July 8, 1944  
 that I last saw him alive on July 8, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arterio Sclerosis  
Acute nephritis  
 Due to Chronic nephritis  
 Due to Hypertension

Duration
<u>7-5-44</u>
<u>2 mos.</u>
<u>1 yr.</u>
<u>2 yrs.</u>

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of work) (e) Means of injury \_\_\_\_\_

23. Signature W. A. Kinne (M. D. or other)

Address Poplar Bluff, Mo. Date signed 7-13-44

RECEIVED

District Health Office No. 2,

District File Number 714-926

Date Filed 7-20-44

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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, by

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

John H. Holt

Licensed Embalmer No. 4264

P. O. Address Fredericktown, 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.**