

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

Aug 9 1946

FILED AUG 19 1946

State File No. 26269

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 193

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

1. PLACE OF DEATH:

(a) County Roone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days
(Specify whether
In this community 36 Years
years, months or days)

3. (a) PRINT FULL NAME WILLIAM RAYMOND WEST

3. (b) If veteran, name war None 3. (c) Social Security No. 490-07-3216

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Kathryn McGee West 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased 11 - 16 - 1909
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 22 If less than one day hr. min.

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

10. Usual occupation Cab Driver

11. Industry or business

MOTHER FATHER

12. Name T.B. West

13. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Alice Rader

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

16. (a) Informant Mrs. Kathryn West

(b) Address 505 W. Ash St., Columbia, Mo.

17. (a) Burial (b) Date thereof 8-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)
Oakland Cemetery

(c) Place: burial or cremation

18. (a) Signature of funeral director Parker Funeral Service
(b) Address Columbia, Mo.

19. (a) 8-9-46 (b) Mrs. R.E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
(c) City or town Columbia 2
(If outside city or town limits, write "RURAL")
(d) Street No. 505 W. Ash St. 4
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 8
year 1946 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from Aug. 1st
1946, to Aug. 8th, 1946
that I last saw him alive on Aug. 8th
and that death occurred on the date and hour stated above. 1946

Immediate cause of death Hemiplegias
Due to Hypertension, cause undetermined.
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 83d

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 place) (c) Means of injury
23. Signature James M. Baker (M. D. or other) MD
Address Columbia, Mo. Date signed Aug. 9, 1946

RECEIVED
District Health Officer No. 9
District File Number 8-46-146
Date Filed 8-12-46

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 *M. A. Whitesides*
Licensed Embalmer No. *2893*
P. O. Address. *Columbia, 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.