

FILED SEP 3 1946

Registration District No. 274

Primary Registration District No. 5935

Registrar's No. 345

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

1. PLACE OF DEATH:
 (a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Route # 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 in this community 60 Years
 years, months or days)

3. (a) PRINT FULL NAME Thomas Chambers West
3. (b) If veteran, name war _____ **3. (c) Social Security No.** _____

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma **6. (c) Age of husband or wife if alive** 68 years
7. Birth date of deceased February 12 1874
 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Edwardsville Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name J. Ben West
13. Birthplace Virginia
 (City, town, or county) (State or foreign country)
14. Maiden name Katherine Pratt
15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. T. C. West
(b) Address Route # 2 Sedalia Mo.
17. (a) Burial (b) Date thereof Aug. 16, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crown Hill Cemetery

18. (a) Signature of funeral director McLaughlin Bros.
(b) Address Sedalia, Missouri
19. (a) 8-20-46 (b) Betty Yeager
 (Date received local registrar) (Registrar's signature)
 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pettis
 (c) City or town Sedalia
 (If outside city or town limits, write "RURAL")
 (d) Street No. Route # 2
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August 13th, 1946
 year 1946, hour _____ minute 8:30 P.M.

21. I hereby certify that I attended the deceased from
July, 25, 1946, 19____, to August, 13, 1946, 19____;
 that I last saw him alive on August, 13, 1946, A.M., 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular-renal syndrome. **Duration** prolonged.
 Due to Arterio-sclerosis, myocarditis.

Due to XXX
XXX
 Other conditions None.
 (Include pregnancy within 3 months of death)

Major findings: No operation.
 Of operations XXX
Of autopsy No autopsy,
XXX

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) No.
 (b) Date of occurrence XXX
 (c) Where did injury occur? XX
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
No injury.

While at work XX (Specify type of place) (a) Means of injury XX
23. Signature B. J. Traders (M. D. or other) M.D.
 Address Sedalia, Mo. Date signed 8-14-1946

RECEIVED

District Health Officer No. 8,

SI- Number

8-31-44

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..... *K. P. M. Crary*

Licensed Embalmer No. *3153*

P. O. Address. *Sedalia 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.