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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17282

Registration District No. 141 Primary Registration District No. 5550 Registrar's No. 16

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Caulfield Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RFD 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 35 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. RFD
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Jno Preston West
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Mo
5. Color or race W
6. (a) ~~Single, widowed~~, married, ~~divorced~~ M
6. (b) Name of husband or wife Cynthia West
6. (c) Age of husband or wife if alive 60 yrs
7. Birth date of deceased 11-27-1874 (Month) (Day) (Year)

8. AGE: Years 72 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lee County (City, town, or county) Virginia (State or foreign country)
10. Usual occupation Farming
11. Industry or business .....
FATHER
12. Name Michael West
13. Birthplace ..... (City, town, or county) Tennessee (State or foreign country)
MOTHER
14. Maiden name Lydia Ely
15. Birthplace ..... (City, town, or county) Virginia (State or foreign country)
16. (a) Informant Cynthia West
(b) Address Caulfield, Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 4-6-47 (Month) (Day) (Year)
(c) Place: burial or cremation Fowler
18. (a) Signature of funeral director Robertsons
(b) Address West Plains, Mo
19. (a) May 8-1947 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5 year 1947 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from 6 March 1947, to 5 Apr 1947; that I last saw him alive on 6 March 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

95 C

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 Bean Hunt (M. D. or other) MD
Address West Plains, Mo Date signed 10 Apr 47
R. Hunt

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 547304
Date Filed 5-20-47

DEC 1948

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.....

P. O. Address.....

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.