

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23478**
Registrar's No. **884**

Registration District No. **42**

Primary Registration District No. **4053**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **De Kalb**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
De Kalb, Mo. No address (Street)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Not** (Specify whether
In this community **Lifetime** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** //
(c) City or town **De Kalb, Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **None.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24th**
year **1947** hour **12** minute **10 A.M.**
21. I hereby certify that I attended the deceased from **July 24**
1947 to **July 24** **1947**
that I last saw her **or** alive on **July 24** **1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Aneurysm**
Duration **12 hrs**

Due to **High blood pressure**

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 place) (e) Means of injury

23. Signature **E. B. McEdow** (M. D. ~~_____~~)
Address **De Kalb Mo** Date signed **July 25 1947**

3. (a) PRINT FULL NAME **Hattie T. West**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 23 1870**
(Month) (Day) (Year)

8. AGE: Years **76** Months **11** Days **1**
If less than one day hr. min.

9. Birthplace **De Kalb Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business

12. Name **T. W. West**
13. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Jane Chitwood**
15. Birthplace **De Kalb Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Homer H. West**
(b) Address **De Kalb, Missouri.**

17. (a) **Burial** (b) Date thereof **July 24, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Westlawn Cemetery**

18. (a) Signature of funeral director **Walter Meierhoffer**
(b) Address **1946 Colhoun St., St. Joseph, Mo.**

19. (a) **7-26-47** (b) **E. B. Jenkins**
(Date received local registrar) (Registrar's signature) **302**

