S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 25 1947

Registration District No. 3947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 40520
Registrar's No. 2407

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 92 days (Specify whether years, months or days)
In this community: 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: —
(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 4145 Evans Street 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: WESTLEY, DANIEL
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: Male
5. Color or race: Negro 2
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: April (Month) 6 (Day) 1920 (Year)

8. AGE: Years 27 | Months 7 | Days 4 | If less than one day: hr. min.

9. Birthplace: Charleston (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business:
FATHER
12. Name: George Westley
13. Birthplace: Alabama (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Julie Mollie Frazier
15. Birthplace: Mississippi (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11/21/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Carbondale, Ill.
18. (a) Signature of funeral director: Russell Und., Co.
(b) Address: 2732 Pine Street
19. (a) 11-21-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20 year 1947 hour 12 minute 55 P. M.

21. I hereby certify that I attended the deceased from 8-19- 1947, to 11-20- 1947; that I last saw him alive on 11-20- 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	6 mo. (??)
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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: 0

23. Signature: W. C. Banton M.D. (M. D. ~~or other~~)
Address: Robert Koch Hospital Date signed 11-21-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Clarke Young

Licensed Embalmer No. 3371

P. O. Address St. Louis

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.