

No. 300  
M-10-47  
y. 5-17-39  
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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31525**  
Registrar's No. **8513**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
The Peoples Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Same day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL")  
(d) Street No. 464 1/2 Page Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jean West  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 1 year 48 hour 3 minute 26 M.  
21. I hereby certify that I attended the deceased from 8/11/48 to 9/1/48 that I last saw him alive on 9/1/48 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Col  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 9 1 48  
(Month) (Day) (Year)

Immediate cause of death Asphyxiation Duration acute  
Due to Conjestion of Lungs  
Due to \_\_\_\_\_  
Other conditions 161  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
4 hr. 0 min.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Richard C. West  
13. Birthplace Miss. (State or foreign country)  
14. Maiden name Dorothy Huggins  
15. Birthplace Miss. (State or foreign country)

16. (a) Informant North West  
(b) Address Anatomical Board  
17. (a) \_\_\_\_\_ (b) Date thereof SEP 30 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Anatomical Board

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 A. James (M. D. or other)  
Address 4730 1/2 Page Date signed 9/1/48

18. (a) Signature of funeral director Richard Mortuary Service  
(b) Address 4104 Manchester Ave.  
19. (a) SEP 30 1948 (b) J. J. Brueck  
(Date received by registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.**