

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 1949

State File No. ....

No. 300  
10-48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8216**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Richmond Heights</b>	
c. LENGTH OF STAY (In this place) <b>25 days</b>		d. STREET ADDRESS (If rural, give location) <b>8000 Elnora Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Christopher</b> b. (Middle) <b>Columbus</b> c. (Last) <b>West</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 21 1949</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>3/8/1896</b>		9. AGE (In years last birthday) <b>53</b>		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>13</b> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>DUSTRY</b>		11. BIRTHPLACE (State or foreign country) <b>Perry Co. Mississippi</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>Sam West</b>		13b. MOTHER'S MAIDEN NAME <b>Winnie McSwain</b>		14. NAME OF HUSBAND OR WIFE <b>Julia West</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Julia West</b>	
				ADDRESS <b>8000 Elnora Street</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain abscess</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15-18 mo.</b>	
		ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> <b>DUE TO (b)</b> _____ <b>DUE TO (c)</b> _____			
		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis MO</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>342X</b>	

22. I hereby certify that I attended the deceased from **Aug. 27, 1949**, to **Sept. 21, 1949**, that I last saw the deceased alive on **Sept. 21, 1949**, and that death occurred at **10:08 AM**, from the causes and on the date stated above.

23a. SIGNATURE <b>F.R. Bradley</b>		(Degree or title) <b>MD</b>		23b. ADDRESS <b>Barnes Hospital</b>	
23c. DATE SIGNED <b>9/21/49</b>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 26 49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Gates</b>		ADDRESS <b>4107 Finney Ave.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 23 1949</b>		REGISTRAR'S SIGNATURE <b>J.B. Lasater</b>			

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

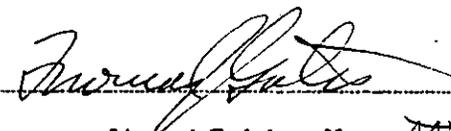
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. ~~4475~~ 4259

P. O. Address 4107 Finney Avenue

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.