

FILED APR 23 1951

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 12303

0396
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>341</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>12 hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Campbell Township</u>		0390		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Johns Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Route #3</u> <u>Oak Grove Lane, Springfield</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>I.</u>			b. (Middle) <u>Cary</u>		c. (Last) <u>West</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 16 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 12, 1884</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repair Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own repair Shop</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>W. A. West</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy James</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine West</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Catherine West, Springfield, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis Heart</u> <u>Disease with congestive failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Few</u> <u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>(207) (51)</u>				
22. I hereby certify that I attended the deceased from <u>6/14/50</u> , 19 <u>50</u> , to 4/16 <u>4/16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/15/51</u> , 19 <u>51</u> , and that death occurred at <u>12:45A</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Glenn O. Turner, M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>4/16/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 18, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Eastlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>4-18-51</u>		REGISTRAR'S SIGNATURE <u>W. E. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alma Schmeier, Springfield, Mo.</u>				

Turner

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 *Bernard F. Wright*

Licensed Embalmer No. *4293*

P. O. Address *Springfield, Mo.*

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.