

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39005

State File No. 5283

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 36 YEARS		d. STREET ADDRESS (If rural, give location) 6430 EAST-16TH STREET	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6430 EAST-16TH STREET			
3. NAME OF DECEASED a. (First) SAMUEL		b. (Middle) M.	
c. (Last) WEST		4. DATE OF DEATH (Month) (Day) (Year) DEC-1-1952	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT-24-1869
9. AGE (In years last birthday) 83		10. AGE (In years last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 3 YEARS JANITOR		10b. KIND OF BUSINESS OR INDUSTRY SECURITY MANUFACTURING CO.	
11. BIRTHPLACE (City and State or Foreign Country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WEST		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE Mrs. MARY F. WEST			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 492-18-0205	
17. INFORMANT'S SIGNATURE OR NAME MRS. MARY F. WEST		ADDRESS 6430 EAST-16TH ST. KANSAS CITY, MO.	
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) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Arteriosclerosis Generalized	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 28 , 1952, to Dec 1 , 1952, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:25 A. m., from the causes and on the date stated above.			
23a. SIGNATURE Paul A. G. Johnson (Degree or title) M.D.		23b. ADDRESS 3011 A Linden Ave	
23c. DATE SIGNED Dec 1-1952			
24a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24b. DATE DEC-3-1952	
24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
DATE REC'D BY LOCAL REG. 12-3-52		REGISTRAR'S SIGNATURE Seraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE W. H. Newcomer		ADDRESS 1331 DROSH CREEK KANSAS CITY MO.	

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 Robert E. Herman

Licensed Embalmer No. 4849

P. O. Address R. E. 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.