

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16832

FILED APR 21 1953

BIRTH NO. _____		REG. DIST. NO. 356		PRIMARY REG. DIST. NO. 4521		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Houston</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Houston</u> 1070		d. STREET ADDRESS (If rural, give location) <u>0</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>See Rest Home Houston Tex</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sam</u> b. (Middle) <u>Miller</u> c. (Last) <u>West</u>			4. DATE OF DEATH <u>3-28-53</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>6-15-1862</u>		9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work dominating most of working life, even if retired) <u>Farming</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Texas Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Jim West</u>		
13b. MOTHER'S MARRIAGE NAME <u>Mary Handledge</u>		14. NAME OF HUSBAND OR WIFE <u>Ben West</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		
17. INFORMANT'S SIGNATURE OR NAME <u>Ben West</u>		17. ADDRESS <u>Licking 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.				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardiac decompensation</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>				DUE TO (c) <u>unknown</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		334X		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) (Min.)		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 <u>2-28</u> 19 <u>53</u> to <u>3-28</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2-28</u> , 19 <u>53</u> , and that death occurred at <u>9:15</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Scott Kramer M.D.</u>		23b. ADDRESS <u>Houston Mo</u>		23c. DATE SIGNED <u>3-31-53</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>3-30-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Licking Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Licking Mo</u>		
DATE REC'D BY LOCAL REG. <u>4-21-53</u>		REGISTRAR'S SIGNATURE <u>Clyde A. Bridget</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Ferguson</u> ADDRESS _____				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFAADING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Robert Ferguson

Licensed Embalmer No. 3945

P. O. Address Leckling Md

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.