

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22635

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 605-1 Registrar's No. 149

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Charles</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>St. Charles</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R.R. #1</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <b>R.R. #1</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>IDA</b> b. (Middle) <b>VIRGINIA</b> c. (Last) <b>WEST</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 30, 1953</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>February 5, 1875</b>	9. AGE (In years) (last birthday) <b>78</b> if UNDER 1 YEAR Months <b>4</b> Days <b>25</b> if UNDER 10 Hrs. Hours <b>25</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Pine Bluff, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>John Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>G.B. 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. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Nola Hutch, R.R. #1, St. Charles, Mo.</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>  ANTECEDENT CAUSES DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Rheumatoid arthritis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 yrs.</b> <b>20 yrs.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4221</b>		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 2-22-47, 1947, to 6-30-53, 1953, that I last saw the deceased alive on 6-27-, 1953, and that death occurred at 9:30A m., from the causes and on the date stated above.

23a. SIGNATURE <b>Chas. Hamilton</b>		Degree or title) <b>M.D.</b>		23b. ADDRESS <b>114 N. Main St., St. Chas. Mo.</b>		23c. DATE SIGNED <b>7-1-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 1, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Pine Bluff, Arkansas</b>	

DATE REC'D BY LOCAL REG. <b>July 1, 1953</b>		REGISTRAR'S SIGNATURE <b>Fannie Hamilton</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Franklin H. ...</b>		ADDRESS <b>St. Charles, Mo.</b>	
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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 .....  
Signature of Student Embalmer

Signed *Clarence M. Billa*

Licensed Embalmer No. *4375*

P. O. Address *St Charles*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.