

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **34295**

Registrar's No. **9379**

FILED OCT 15 1953

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 34295	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St Louis		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				e. STREET ADDRESS (If rural, give location) 3220 Ohio			
3. NAME OF DECEASED (Type or Print) a. (First) WALTER		b. (Middle) L.		c. (Last) WEST, Jr.		4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 29, 1953	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Oct 27, 1884	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Walter L West			13b. MOTHER'S MAIDEN NAME Prudent Smith		14. NAME OF HUSBAND OR WIFE Lena West		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 497-03-8954		17. INFORMANT'S SIGNATURE OR NAME Lena West ADDRESS 3220 Ohio			
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES Carcinoma of Larynx Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 6 months
19a. DATE OF OPERATION 1947		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Larynx				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? 161X			
22. I hereby certify that I attended the deceased from 7-27-53 , 19____, to 9-29-53 , 19____, that I last saw the deceased alive on 9-29-53 , 19____, and that death occurred at 1:03P m., from the causes and on the date stated above.							
23a. SIGNATURE Charles S. Buren, D.O. M.D. (Degree or title)				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 9-29-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/2/53		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) Affton, Mo.	
DATE REC'D BY LOCAL REG. SEP 30 1953		REGISTRAR'S SIGNATURE Charles Smith		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons ADDRESS 7027 Gravois			

(Licensed Embalmer's Statement on Reverse Side)

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 *E. P. K. Dwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Bra*

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.