

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30352

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5459 Registrar's No. 882

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural 3<sup>rd</sup> Center</b>		c. CITY OR TOWN <b>Springfield</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Six Miles South Ash Grove</b>		e. STREET ADDRESS (If rural, give location) <b>1421 West Phelps 0290</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Cedric</b> b. (Middle) <b>Arvel</b> c. (Last) <b>West</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 19-1954</b>
--	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>January 2-1904</b>	9. AGE (In years) (last birthday) <b>50</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS Days <b>17</b>	IF UNDER 24 HRS Hours <b></b>	IF UNDER 24 HRS Min. <b></b>
--------------------	-------------------------------	---	--	---	------------------------------------	-----------------------------------	----------------------------------	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Maintenance</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lily Tulip Cup Corp.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Greene Co. Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
--	---	---	---

13a. FATHER'S NAME <b>T. E. West</b>	13b. MOTHER'S MAIDEN NAME <b>Texanna Mynatt</b>	14. NAME OF HUSBAND OR WIFE <b>Ica Mae West</b>
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>491-03-1602</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ica Mae West</b>	ADDRESS <b>Springfield 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		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) <b>Coronary Occlusion</b>		
	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	19b. MAJOR FINDINGS OF OPERATION <b>4201</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 <input type="checkbox"/> 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 **9/19**, 1954, to **9/19**, 1954, that I last saw the deceased alive on **9/19**, 1954, and that death occurred at **12:40 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b>	(Degree or title) <b>2</b>	23b. ADDRESS <b>Oak View Mo</b>	23c. DATE SIGNED <b>9/20/54</b>
-----------------------------------	----------------------------	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept. 21-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Johns Chapel</b>	24d. LOCATION (City, town, or county) (State) <b>5 miles South Ash Grove Mo.</b>
---	--------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>9-21-54</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	2. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>2015 Birch Ash Grove Mo.</b>
---	--	--	---

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

390

SEP 27

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 *Richard E. Watt*.....

Licensed Embalmer No. *465*.....

P. O. Address *Ash Grove*.....

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.