

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

FILED MAY 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15288

BIRTH NO. _____		REG. DIST. NO. <u>138</u>		PRIMARY REG. DIST. NO. <u>5528</u>		Registrar's No. <u>9</u>	
1. PLACE OF DEATH a. COUNTY <u>Hickory</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Rural-Weaubleau, T. 5.</u>		c. LENGTH OF STAY (in this place) <u>10 years</u>		c. CITY OR TOWN <u>Rural</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6 Miles S.E. Weaubleau</u>				e. STREET ADDRESS (If rural, give location) <u>6 Miles S.E. of Weaubleau</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Emec</u> c. (Last) <u>West</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 19-1955</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 8-1867</u>		9. AGE (in years) (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Red Rock Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELIAF F. West</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Carr</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel 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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harvey P. West - Wheatland, Mo</u> ADDRESS _____			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>varicose veins of left leg</u>					years <u>4201</u>	
	DUE TO (c) <u>Smoking</u>						
	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				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 <u>May 18</u> , 19 <u>55</u> , to <u>May 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>55</u> , and that death occurred at <u>2:25 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L. H. Briggs, D.O.</u>			23b. ADDRESS <u>Wheatland, Mo.</u>			23c. DATE SIGNED <u>May 29, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>May 22-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Warsaw, Mo</u>		
DATE REC'D BY LOCAL REG. <u>5-21-1955</u>		REGISTRAR'S SIGNATURE <u>Mary Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer H. Hethaway, Wheatland, Mo.</u> ADDRESS _____			

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 *Chas. Gilbert Hathaway*

Licensed Embalmer No. *426*

P. O. Address *Wheaton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.