

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32139

State File No.

BIRTH NO. _____ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3002 Registrar's No. 205

1. PLACE OF DEATH a. COUNTY <u>Andrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Mexico</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Middletown</u>	
c. LENGTH OF STAY (In this place) <u>5 days</u>		d. STREET ADDRESS (If rural, give location) <u>NONE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Andrain Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>GERTRUDE MARY WEST</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 21 1955</u>		
a. (First)	b. (Middle)	c. (Last)	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 2 WKS. Days
<u>GERTRUDE</u>	<u>MARY</u>	<u>WEST</u>	<u>71</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>MAR. 2, 1884</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Middletown Mo.</u>
10a. USUAL OCCUPATION	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		

13a. FATHER'S NAME <u>David May</u>	13b. MOTHER'S MAIDEN NAME <u>Mildred May</u>	14. NAME OF HUSBAND OR WIFE <u>William West</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>James W. West 714 St. Louis</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Occlusion</u>			<u>15 years</u>
ANTECEDENT CAUSES	DUE TO (b) <u>Coronary Artery disease</u>		<u>15 years</u>
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <u>Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>4201</u>		
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) (Minute)	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 10-17, 1955, to 10-21, 1955, that I last saw the deceased alive on 10-20, 1955, and that death occurred at 6:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. D. Shuman</u>	(Degree or title) <u>Co. J. Troop 20</u>	23b. ADDRESS <u>10-21-55</u>	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 23rd</u>	24b. DATE <u>Oct. 23-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Middletown Mo</u>
DATE RECD BY LOCAL REG. <u>Oct. 21-1955</u>	REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Britchett</u>	ADDRESS <u>Middletown, Mo</u>

(Licensed Embalmer's Statement on Reverse Side) F. B. Kelly

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
Student Embalmer

Signed _____

Licensed Embalmer No. 1588

P. O. Address Wellsville N.Y.

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.