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FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37476

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 207 PRIMARY REG. DIST. NO. 5756 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY Maries		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Maries	
b. CITY OR TOWN Rural Detterson Twnsh.		c. CITY OR TOWN Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Family Home		e. STREET ADDRESS (If rural, give location) Detterson Township	

3. NAME OF DECEASED (Type or Print) a. (First) Christena b. (Middle) West c. (Last) West			4. DATE OF DEATH (Month) (Day) (Year) Nov 28 1955		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Aug 28 - 1871		9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Fred Miller			13b. MOTHER'S MAIDEN NAME _____			14. NAME OF HUSBAND OR WIFE Geo. West		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Geo West		ADDRESS Belle-Mo.	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease						Years	
		DUE TO (c) Generalized arteriosclerosis						Yrs	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility						4200	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 **July 15, 1952**, to **Nov 28, 1955**, that I last saw the deceased alive on **Nov 3, 1955**, and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE F. L. Kozal, M.D.		23b. ADDRESS Belle, Mo.		23c. DATE SIGNED 12-2-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov 30 - 1955		24c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery		24d. LOCATION (City, town, or county) (State) Belle - Mo.	
DATE REC'D BY LOCAL REG. 12-3-55		REGISTRAR'S SIGNATURE Pauline Howard		25. FUNERAL DIRECTOR'S SIGNATURE SASSMANN'S Funeral Service		ADDRESS Belle - Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

0630

0630

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.....
Chester Sasmann

Licensed Embalmer No. *417*

P. O. Address.....
Bland

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