

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42762

State File No. ....

FILED JAN 17 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11611**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>4 days</b>	c. CITY OR TOWN <b>St. Louis</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>St. Louis City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1302 Laurel</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lyne</b>	b. (Middle) <b>B.</b>	c. (Last) <b>West</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 31st 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>May 18th 1881</b>	9. AGE (in years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John L. West</b>	13b. MOTHER'S MAIDEN NAME <b>Melinda ????</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unavailable</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Harold Webb, Maplewood, Mo.</b>	ADDRESS <b>2848 Oakland</b>
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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, asthma, 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) <b>Fracture of Left Hip</b> <b>Generalized Atherosclerosis; suffered in fall at home on November 18, 1955.</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>18. 1955.</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Nov 18 55? m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>000 904.0<sub>21</sub></b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **9:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>James M. Kelly</b>	(Degree or title)	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>1/3/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-3-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 3 1956</b>	REGISTRAR'S SIGNATURE <b>J. B. Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>JAY B. SMITH, Maplewood, Missouri</b>	ADDRESS
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*m 276.* (Licensed Embalmer's Statement on Reverse Side)

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

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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 Not embalmed, Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed H. E. Burgess.....

Licensed Embalmer No. 417.....

P. O. Address Maple.....

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.