

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11722

State File No. ....

FILED MAR 25 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 3072 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>	c. CITY OR TOWN <u>Marshall</u> <u>1972</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <u>414 East Gordon</u>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Frances</u>	b. (Middle) <u>West</u>	c. (Last) <u>Christie</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 19th, 1957.</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 19, 1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Mins. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William E. West</u>	13b. MOTHER'S MAIDEN NAME <u>Eliza Jane Armstrong</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs George Holt, Marshall, Mo.</u>	ADDRESS _____
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Right Heart Failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cor Pulmonale</u> 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 _____	20. AUTOPSY? <u>2</u> 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) <u>4343</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from May, 1953, to March, 1957, that I last saw the deceased alive on March 19, 1957, and that death occurred at 3:30 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>James A. Reed MD</u> (Degree or title)	23b. ADDRESS <u>Marshall Mo</u>	23c. DATE SIGNED <u>3-20-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Mch. 22, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3-22-57</u>	REGISTRAR'S SIGNATURE <u>Carl H. Reed</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Campbell-Lewis</u>	ADDRESS <u>Marshall Mo.</u>
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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 ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *James H. Lewis*

Licensed Embalmer No. *4709*

P. O. Address *Marshall, Mo*

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.