

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27128

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 324 Primary Registration District No. 30721 Registrar's No. 144

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Memorial Hospital</u>			d. STREET ADDRESS <u>419 So. Jefferson</u>	e. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>(none)</u> Last <u>West</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1877</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe salesman</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Tom West</u>			14. MOTHER'S MAIDEN NAME <u>Marianna Anthony</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 Address <u>Mrs. Etta West Slater, Missouri</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic Ileus, Impaction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>/</u> DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5701</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>July 31</u> to <u>Aug 1</u> and last saw her/him alive on <u>Aug 1</u> . Death occurred at <u>3:30</u> <u>a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>P. L. Lawless M.D.</u> (Degree or title)			22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED <u>8-3-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>August 3, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgepark Cemetery</u>	23d. LOCATION (City, town, or county) <u>Marshall</u>	23e. (State) <u>Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Walter J. Haines Jr. Slater Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-3-57</u>	26. REGISTRAR'S SIGNATURE <u>Cecil J. Read</u>		

(Licensed Embalmer's Statement on Reverse Side)

29-0

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 *Walter J. Haines*.....
Licensed Embalmer No. *4*.....

P. O. Address *State*.....

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.