

FILED OCT 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35199**

BIRTH NO. _____ REG. DIST. NO. **74** PRIMARY REG. DIST. NO. **5295** Registrar's No. **471**

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give town) Plattsburg		c. CITY OR TOWN Stewartsville	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 12 1/2		e. STREET ADDRESS (If rural, give location) 02300	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lewis Nursing Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Sarah	b. (Middle) Madie	c. (Last) West	4. DATE OF DEATH (Month) (Day) (Year) 10/ 16/ 57
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May, 20, 1877	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Clinton Co. Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John W. Berry	13b. MOTHER'S MAIDEN NAME Clarisa Jane Miller	14. NAME OF HUSBAND OR WIFE W. Curtis West
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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) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Carl Watson	ADDRESS Stewartsville 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial		INTERVAL BETWEEN ONSET AND DEATH 14 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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? 2 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) 4222
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **Oct 1, 1957**, to **Oct 16, 1957**, that I last saw the deceased alive on **Oct 15, 1957**, and that death occurred at **3:30 am.**, from the causes and on the date stated above.

23a. SIGNATURE W. B. Shalading MD (Degree or title)	23b. ADDRESS Plattsburg Mo	23c. DATE SIGNED Oct 16 1957
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/17/57	24c. NAME OF CEMETERY OR CREMATORY Evergreen	24d. LOCATION (City, town, or county) (State) Osborn, Mo.
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DATE REC'D BY LOCAL REG. Oct. 18, 1957	REGISTRAR'S SIGNATURE Elizabeth Acearce	25. FUNERAL DIRECTOR'S SIGNATURE W. E. Summerfield	ADDRESS Stewartsville
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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 *W.E. Ammerfeld*

Licensed Embalmer No. 3007

P. O. Address *Stevensville*

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.