

Public Health,
 Health, Safety & Welfare
 U. S. Public Health Service

FILED DEC 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40783
 STATE FILE NUMBER
 3026 Registrar's No. 514

Registration District No. 146 Primary Registration District No. 3026

U. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City 22		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Sanit.		Length of stay in lb 3 days	d. STREET ADDRESS (If outside, give location) 8727 Wilson Road		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HELEN Middle FAYE Last WEST			4. DATE OF DEATH Month Nov. Day 22 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1933	9. AGE (In years last birthday) 24 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Gateway Spt. Goods.		11. BIRTHPLACE (City and state or country) Warsaw, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Chas. H. Whittall		13b. MOTHER'S MAIDEN NAME Neil O. Williams	
14. NAME OF HUSBAND OR WIFE Gail B. West		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 487-34-5789	
17. INFORMANT Chas. H. Whittall		Address 8727 Wilson Rd., K.C. 22, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure heart					INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) Myocardial Infarction and aortic stenosis with regurgitation					12 yrs.
DUE TO (c) Rheumatic heart disease					12 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410X					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <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 1952 to 11-22-57 and last saw her alive on Nov. 22, 1957 Death occurred at 3:20 P. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Hedell Amb. M.D.		22b. ADDRESS 10222 Indep. Rd. K.C. 22 Mo.		22c. DATE SIGNED 11/23/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 25, 1957	23c. NAME OF CEMETERY OR CREMATORY Greenridge		23d. LOCATION (City, town, or county) (State) Greenridge, Missouri
24. FUNERAL DIRECTOR George C. Carson, Independence, Mo.		25. DATE RECD. BY LOCAL REG. 11-25-57		26. REGISTRAR'S SIGNATURE James S. Craig	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

3540

DEC 9 1957

DEC 4 1957

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 *A Kenneth Patterson*

Licensed Embalmer No. *4697*
P. O. Address *Indep. 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.