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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1000

STATE FILE NUMBER

FILED JAN 20 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Strafford Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hosp. Length of stay in lb weeks		d. STREET ADDRESS (If outside, give location) Route 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Harvey Last West.			4. DATE OF DEATH Month Jan. Day 9 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1887
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 3 Days 9	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe repairman		10b. KIND OF BUSINESS OR INDUSTRY Shoe shop	11. BIRTHPLACE (City and state or country) Strafford, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME John William West		13b. MOTHER'S MAIDEN NAME Frances Elizabeth Mitchell-	14. NAME OF HUSBAND OR WIFE -----
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. 560-05-1485	17. INFORMANT (Son) Alfred West Address Salt Lake City, Utah
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X			19. WAS AUTOPSY PERFORMED? 2 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 12/27/57 to 1/9/58 and last saw ^{her} him alive on 1/9/58 Death occurred at 6:00 p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leman M. Brown M.D.		22b. ADDRESS 311 1/2 College	22c. DATE SIGNED 1/11/58
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE 1-12-'58	23c. NAME OF CEMETERY OR CREMATORY Mullinax Cemetery	23d. LOCATION (City, town, or county) (State) Strafford, Missouri
24. FUNERAL DIRECTOR Jim Jamieson		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 1-13-58
26. REGISTRAR'S SIGNATURE Effie S. Melton			

(Licensed Embalmer's Statement on Reverse Side)

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 

Licensed Embalmer No. 3312
P. O. Address Springfield, M

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.