

FILED MAR 20 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011080

STATE FILE NUMBER

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 46

300
-57

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wynesville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural Union</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in lb <u>4 weeks</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Emmitt</u> Last <u>West</u>			4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/1869</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Thomas J. West</u>			13b. MOTHER'S MAIDEN NAME <u>Lovie Stran</u>			14. NAME OF HUSBAND OR WIFE <u>Nora West</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. Emmitt West, Dixon, 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>Pneumonia, bronchitis Terminal</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Angina of heart left</u>			1 month			
		DUE TO (c) <u>Rupture of blood vessel below</u>			9:30 AM 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input checked="" 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.) <u>while walking - car</u>					
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> p.m. <u>2</u> <u>11</u> <u>1958</u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Spain</u>			COUNTY <u>Marion</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>Nov 27, 1957</u> , to <u>Mar 11, 1958</u> and last saw him alive on <u>Mar 11, 1958</u> Death occurred at <u>8:35 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>C. M. Mott</u>				22b. ADDRESS <u>Crocker, Mo</u>		22c. DATE SIGNED <u>3-13-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/13/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dixon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dixon, Missouri</u>			
24. FUNERAL DIRECTOR <u>Gilbert Funeral Home, Inc., Dixon, Mo.</u>			ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>3-13-58</u>		26. REGISTRAR'S SIGNATURE <u>Ceola Groe Anderson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 10 1958

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 *Maurice E Schirbaum*

Licensed Embalmer No. *4505*

P. O. Address *Dixon, Missouri*

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.