

FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI,  
STANDARD CERTIFICATE OF DEATH

58-012474  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2818**

300  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS HOSPITAL ON GRAND</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>17 3952 SHAW</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOMER WEST</b>			4. DATE OF DEATH Month Day Year <b>MARCH 7 1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3 1912</b>	9. AGE (In years last birthday) <b>45</b> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAY LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or county) <b>MISSOURI</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>		13a. FATHER'S NAME <b>RICHARD WEST</b>		13b. MOTHER'S MAIDEN NAME <b>MARY REED</b>	
13c. NAME OF HUSBAND OR WIFE <b>DOROTHY WEST</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DOROTHY WEST</b>		Address <b>3932 SHAW</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Mucous plug in the Bronchus;</b> DUE TO (c) <b>Carcinoma of the Larynx</b> PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Anesthesia.</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. If the nature of injury is not apparent in PART I of item 18. <b>Stroke during operation (Cancer of throat) at Veterans' Hospital</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>3 7 p.m.</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>19 Hosp</b>			
20e. CITY/TOWN, OR LOCATION <b>St. Louis Mo.</b>		20f. COUNTY STATE			
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at <b>5:35 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>James M. Kelly</b> (Degree or title) <b>Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>3-10-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL MARCH 11 1958 NATIONAL CEMETERY JEFFERSON BARRACKS MO</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR <b>Thomas Kuttis</b> ADDRESS <b>2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 10 58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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 *Leo J. Budde* .....

Licensed Embalmer No. *3989* .....

P. O. Address *St. Louis* .....

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.