

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028898  
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 128 Primary Registration District No. Registrar's No. 794B

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>2nd. Jackson Twnshp.</u>		c. CITY OR TOWN <u>Strafford 0390</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>2nd. Jackson Twnshp.</u>	
Length of stay in lb <u>14 yrs.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Zola</u> Middle <u>S.</u> Last <u>West</u>			4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1958</u>		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1891</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Greene County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Thomas Armstrong</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Pettigrew</u>	14. NAME OF HUSBAND OR WIFE <u>Silas J. West (Dec.)</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>500-01-4600</u>	17. INFORMANT (Son) <u>William Harris - Springfield, Mo.</u>	Address
---	---	---	---------

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>Liver malignancy approx. 2 yrs.</u>		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)	<u>1561</u>
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 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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	

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 July 17, 1958 to Aug 10, 1958 and last saw her/him alive on 11 Aug 58.  
Death occurred at 2:20 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harris E. Knaub, M.D.</u> (Degree or title)	22b. ADDRESS <u>1630 N. Jefferson Springfield, Mo.</u>	22c. DATE SIGNED <u>Aug 15, 1958</u>
--	---	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-13-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mullinax Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greene County, Missouri</u>
--	-------------------------------	--	---

24. FUNERAL DIRECTOR <u>Rex Rainey - Springfield, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-18-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Mellen</u>
--	---------	--	---

Doctor, coronary, 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

AUG 2

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, 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.