

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034987

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2417

300
1-57

3

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>High Ridge</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp</u>		Length of stay in lb <u>D.O.A.</u>		d. STREET ADDRESS (If outside, give location) <u>Orchard Drive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bowley</u> Middle <u>E.</u> Last <u>West</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1888</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>9</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>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Ser. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Lindell, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Jake West</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Joyce</u>		14. NAME OF HUSBAND OR WIFE <u>Cecil 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>493-10-9672</u>		17. INFORMANT Address <u>Cecil West, High Ridge, Mo.</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>a cute myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>coronary insufficiency; chronic myocarditis</u> DUE TO (c) <u>rheumatic heart disease; gen. arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>indeterminate</u>		
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>								
20d. INJURY OCCURRED WHILE AT WORK <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 <u>8-17-57</u> , to <u>9-13-58</u> and last saw ^{her} him alive on <u>9-13-58</u> Death occurred at <u>home, 8-18-58</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>S. Schmitz M.D.</u> (Degree or title)				22b. ADDRESS <u>2730 W. BELLE ST.</u>		22c. DATE SIGNED <u>9/20/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>9/22/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>		23d. LOCATION (City, town, or county) <u>BELLE, MISSOURI</u>		(State)	
24. FUNERAL DIRECTOR <u>FROHWITTER-MILLER High Ridge MO</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-20-58</u>		26. REGISTRAR'S SIGNATURE <u>Norbert R. Donke M.D.</u>	

Dr. Samuel Schults
2730 Watson

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 *Merville D. Frohwitter*

Licensed Embalmer No. *3696*

P. O. Address *High Ridge, Pa.*

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.