

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037541

STATE FILE NUMBER

FILED OCT 21 1958

Registration District No. 316

Primary Registration District No. 6069

Registrar's No. 385

S. 300  
ev. 1-57

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.

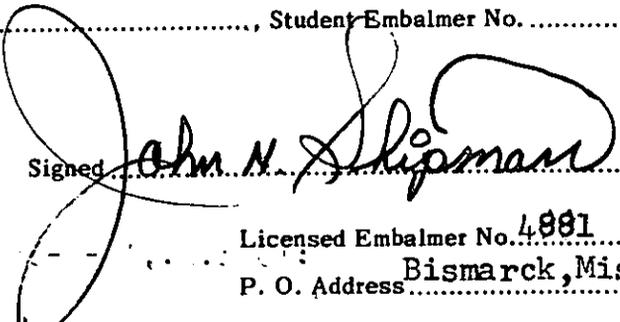
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Iron Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Bismar ck RR#1 0940</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in lb <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>3 Mi. west</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM ORVILLE WEST</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>4,</b> Year <b>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>Aug. 1, 1901</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR: Months <b>2</b> Days <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Factory</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>	11. BIRTHPLACE (City and state or country) <b>Bismarck, RR#1, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>William Franklin West</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Beard</b>		14. NAME OF HUSBAND OR WIFE <b>Leona West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> unknown) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-03-9302</b>	17. INFORMANT <b>Leona West Bismarck, Missouri RR#1</b>		
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>Acute Circulatory Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Occlusion</b>				<b>20 min.</b>	
DUE TO (c) <b>4201</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
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 _____ to _____ and last saw him alive on <b>D.O.A.</b> Death occurred at <b>8:15 A.M., 10-4-58</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>R. A. Hendigate, D.O. 2</b>			22b. ADDRESS <b>Bismarck, Missouri</b>		22c. DATE SIGNED <b>10-7-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-6-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nasonic</b>	23d. LOCATION (City, town, or county) (State) <b>Bismarck, Missouri</b>		
24. FUNERAL DIRECTOR <b>Shipman &amp; Sons Bismarck, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Oct. 15, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>		

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. 4981  
P. O. Address Bismarck, 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.