

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002452  
STATE FILE NUMBER

Registration District No. 280 Primary Registration District No. 4423 Registrar's No. 7

1. PLACE OF DEATH  
a. COUNTY Platte  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Weston Inside Limits Yes  No   
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri b. COUNTY Platte  
c. CITY OR TOWN Weston Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last  
(Type or print) Famelia Ann West

4. DATE OF DEATH Month Day Year  
Jan. 15, 1959

5. SEX Female 6. COLOR OR RACE white 7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED  8. DATE OF BIRTH Jan. 19, 1894 9. AGE (In years last birthday) 67 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (City and state or country) Macon Co. Tenn 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Leon Woodard 13b. MOTHER'S MAIDEN NAME Molly Robinson 14. NAME OF HUSBAND OR WIFE J. K. West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Earl West Address Weston, Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary thrombosis  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis  
DUE TO (c) \_\_\_\_\_  
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  NO

20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE  WORK AT WORK \_\_\_\_\_

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 Jan. 15, 1959 and last saw her alive on \_\_\_\_\_  
Death occurred at 19:30m P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] D.O. 2 22b. ADDRESS Weston, Mo 22c. DATE SIGNED 1-16-59

23a. BURIAL, CREMATION, or other disposition (Specify) Burial 23b. DATE 1-17-1959 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. 23d. LOCATION (City, town, or county) (State) Weston, Missouri

24. FUNERAL DIRECTOR Vaughn Funeral Home ADDRESS Weston, Mo. 25. DATE RECD. BY LOCAL REG. 1-17-1959 26. REGISTRAR'S SIGNATURE [Signature]

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

1956 9 731



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 *W. R. Vaughn* .....

Licensed Embalmer No. *4023* .....  
P. O. Address *Wester, 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.