

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006526
STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Maryville <i>0742</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis		Length of stay in 1b 17 days	d. STREET ADDRESS (If outside, give location) 319 East 6th
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First LUCY	Middle M.	Last WESTFALL	4. DATE OF DEATH	Month 3	Day 10	Year 59
--	-------------------	------------------	----------------------	------------------	----------------	---------------	----------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/71	9. AGE (In years (last birthday)) 87	FUNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-------------------------	----------------------------------	---	------------------------------------	--	-------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Maryville, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	--

13a. FATHER'S NAME James R. Ford	13b. MOTHER'S MAIDEN NAME Elizabeth Alexander	14. NAME OF HUSBAND OR WIFE Henry Westfall, dec.
--	---	--

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 Mrs. W. R. Joel, Pittsburgh, Kans.	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) Unint. & asphyxiated phlegm		INTERVAL BETWEEN ONSET AND DEATH 20 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterio-sclerotic heart disease	
	DUE TO (c) & infarction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) osteoporosis with fractured spine		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 a.m. p.m.	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 174	COUNTY	STATE
---	--	--	--	--------	-------

21. I attended the deceased from 2-19-59 to 3/10/59 and last saw her alive on 3/10/59 Death occurred at 3/10/59 11:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE J. C. Bacon (Degree or title) M. D.	22b. ADDRESS Maryville, Missouri	22c. DATE SIGNED 3/10/59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/12/59	23c. NAME OF CEMETERY OR CREMATORY Oak Hill	23d. LOCATION (City, town, or county) (State) Maryville, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR Price Funeral Home, Maryville, Mo.	25. DATE RECD. BY LOCAL REG. 3-11-59	26. REGISTRAR'S SIGNATURE Bess Bolt
---	--	---

300
1-57
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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.

YS JAN 4 1961

YS NOV 15 1960

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 *Mary Curtis E. Hensley*

Licensed Embalmer No. *4934*

P. O. Address *Maryville, 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.