

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008164

STATE FILE NUMBER

FILED FEB 18 1959

Registration District No. 356

Primary Registration District No. 4521

Registrar's No. 13

300
1-57

1. PLACE OF DEATH a. COUNTY TEXAS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY TEXAS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HOUSTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN HOUSTON-MO 1078
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JOHN CALVIN WEST			4. DATE OF DEATH Month Day Year 2 12 1959		
5. SEX M	6. COLOR OR RACE WHT	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1879	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days - 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) SOLO MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME LEWIS WEST	13b. MOTHER'S MAIDEN NAME MARY FLEENOR	14. NAME OF HUSBAND OR WIFE LYDIA MAE THYON
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address MAUDE-HART HOUSTON MO.
---	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) ARTERIO-SCLEROTIC - HYPERTENSIVE HEART DISEASE		YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CEREBRAL THROMBOSIS		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.) 4201	
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 HOUSTON		COUNTY STATE

21. I attended the deceased from **JAN. 5, 1957** to **FEB. 12, 1959** and last saw him alive on **FEB. 6, 1959**
Death occurred at **7:15 a.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John P. Lewis, M.D.	(Degree or title)	22b. ADDRESS Houston, Mo.	22c. DATE SIGNED 2/13/59
--	-------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-15-59	23c. NAME OF CEMETERY OR CREMATORY OZARK	23d. LOCATION (City, town, or county) (State) S.E. HOUSTON MO
--	-----------------------------	--	---

24. FUNERAL DIRECTOR L. J. Evans	ADDRESS Houston Mo	25. DATE RECD. BY LOCAL REG. Feb. 14-1959	26. REGISTRAR'S SIGNATURE Myrtle Craig
--	------------------------------	---	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MS JUN 2 1952

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 *Lowell C. Craig*

Licensed Embalmer No. *4766*

P. O. Address *Mtn View M*

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.