

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012318
STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 197

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIV. HOSPITAL INSTITUTION <u>Univ. Hospital</u>		Length of stay in 1b <u>3 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>708 Spencer Rd</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Adaline West</u>			4. DATE OF DEATH Month Day Year <u>April 25 1959</u>	
5. SEX <u>Female</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>Sept 6, 1882</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Rush County, Indiana</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>John Rader</u>		13b. MOTHER'S MAIDEN NAME <u>Malinda Tinsley</u>		14. NAME OF HUSBAND OR WIFE <u>T. B. 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>-----</u>		17. INFORMANT <u>Hospital Record</u> Address <u>Columbia, Mo</u> <u>Univ. Hospital</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>Pulmonary edema.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial infarction</u>		<u>2 1/2 days</u>
	DUE TO (c) <u>Arteriosclerotic heart disease</u>		<u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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	COUNTY	STATE
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21. I attended the deceased from 4-26-59 to 4-25-59 and last saw her alive on 4-25-59.
Death occurred at 11:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul B. Sparks, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Univ. Hospital</u>	22c. DATE SIGNED <u>4-26-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/28/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>Columbia, Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u>	ADDRESS <u>Columbia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 27, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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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

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. 4425
P. O. Address

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.