

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039290

STATE FILE NUMBER

FILED VS NOV 18 1959

59

171

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

1. PLACE OF DEATH a. COUNTY <b>Cass</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cass</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Strasburg</b>		Length of stay in 1b <b>lifetime</b>		c. CITY OR TOWN <b>Strasburg</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>no street address</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>no street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Harrison</b> Last <b>West</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1959</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/26/1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance man</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Twp. road</b>		11. BIRTHPLACE (City and state or country) <b>Strasburg, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William H. West</b>			13b. MOTHER'S MAIDEN NAME <b>Amanda Reynolds</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes</b>			16. SOCIAL SECURITY NO. <b>422-24-1121</b>		17. INFORMANT Address <b>Mrs. Jennie Clawson Strasburg, Mo.</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>Apparent Cerebral Hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.		Month, Day, Year _____						
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 <b>dead 11-7-59</b> Death occurred at <b>2 a.m. ?</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John Stephen Shreffel Acc Coram</b>				22b. ADDRESS <b>208 W. Pearl Hillville</b>			22c. DATE SIGNED <b>11-8-59</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Strasburg Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Strasburg, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Brownfield-Stanley Pleasant Hill, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11-9-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Ray Sebrer</b>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS 1718 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Donald B. Wiegans, Student Embalmer No. 594

working under my personal supervision.

Student Donald B. Wiegans  
Signature of Student Embalmer

Signed Raymond A. Star

Licensed Embalmer No. 5008

P. O. Address Pleasant

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.