

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046425

FILED VS DEC 3 0 1960

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6252

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If in institution, give name of institution and date of admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston City</u>		Length of stay in lb <u>60 YRS</u>		c. CITY OR TOWN <u>Paulsboro</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp</u>			d. STREET ADDRESS (If outside, give location) <u>3201 D. Bayfield</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GREEN</u> Middle <u>B</u> Last <u>West</u>			4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>60</u>		
5. SEX <u>Male</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>5-2-1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Smithville, Mo</u>	
13a. FATHER'S NAME <u>William B. West</u>		13b. MOTHER'S MAIDEN NAME <u>Kallie Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Addie P. 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 Address <u>Mrs. Lorene Hopkins 2104 E 52nd</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>Aspiration bronchopneumonia</u> DUE TO (b) <u>and edema</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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 _____ Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>145 12/6/60</u> and last saw him alive on <u>12/9/1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>2400 Cherry - City</u>		22c. DATE SIGNED <u>12/9</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-12-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F. Cem</u>	
23d. FUNERAL DIRECTOR <u>D. W. Newcomer</u> ADDRESS <u>Southern K.K.C.</u>		23e. LOCATION (City, town, or county) <u>Smithville, Mo</u>		23f. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u>	
24. DATE RECD. BY LOCAL REG. <u>12-12-60</u>		25. REGISTRAR'S SIGNATURE			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

E. Frank Ellis

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Glen H. Hice

Licensed Embalmer No. 458

P. O. Address R. C. #8

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