

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-024279

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3 Registrar's No. 2

AMENDED

FILED AUG 1 1961

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff		c. CITY OR TOWN Poplar Bluff	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lucy Lee Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KATHERINE Middle -- Last WEST			4. DATE OF DEATH Month MAY Day 20 Year 1961			
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 11-28-1881	9. AGE (last birthday) 79	IF UNDER 1 YEAR IF UNDER 24 HR Months 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	11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ed Pollock		13b. MOTHER'S MAIDEN NAME Octavia Howell		14. NAME OF HUSBAND OR WIFE Wife of late T.W. West		
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.		17. INFORMANT Address Newport, Ark. Mrs. Dorothy Fife Newport, Ark.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure		2 months
DUE TO (c) Hypertensive Cardiovascular Disease		Unknown

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	
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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 **April 15, 1961** to **20 May 1961** and last saw her/him alive on **20 May 1961**
Death occurred at **5:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John L. Wright, M.D.	22b. ADDRESS POPLAR BLUFF, MO.	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-22-61	23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR Ottie Dillinger Newport, Ark.	25. DATE RECD. BY LOCAL REG. 8-1-61	26. REGISTRAR'S SIGNATURE Mustardwick M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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. _____

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.