

28 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space

19302-1

1. PLACE OF DEATH

County Greene
Township Jackson
City Jackson (No. St. Ward)

Registration District No. 9.6.1
Primary Registration District No. 9.6.1

File No.
Registered No.

2. FULL NAME

Thomas Alvin West

(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 15 - 1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
27 2 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Greene Co Mo. (STATE OR COUNTRY)

10. NAME OF FATHER John Wm West

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Mitchell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown (STATE OR COUNTRY)

14. INFORMANT Mrs. Wilf Clouse (Address) Strofford Mo

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1919

17. I HEREBY CERTIFY That I attended deceased from June 17 1919 to June 20 1919 that I last saw h. l. r. alive on June 20 1919, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis

12.9 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 136 IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No DATE OF WAS THERE AN AUTOPSY? No

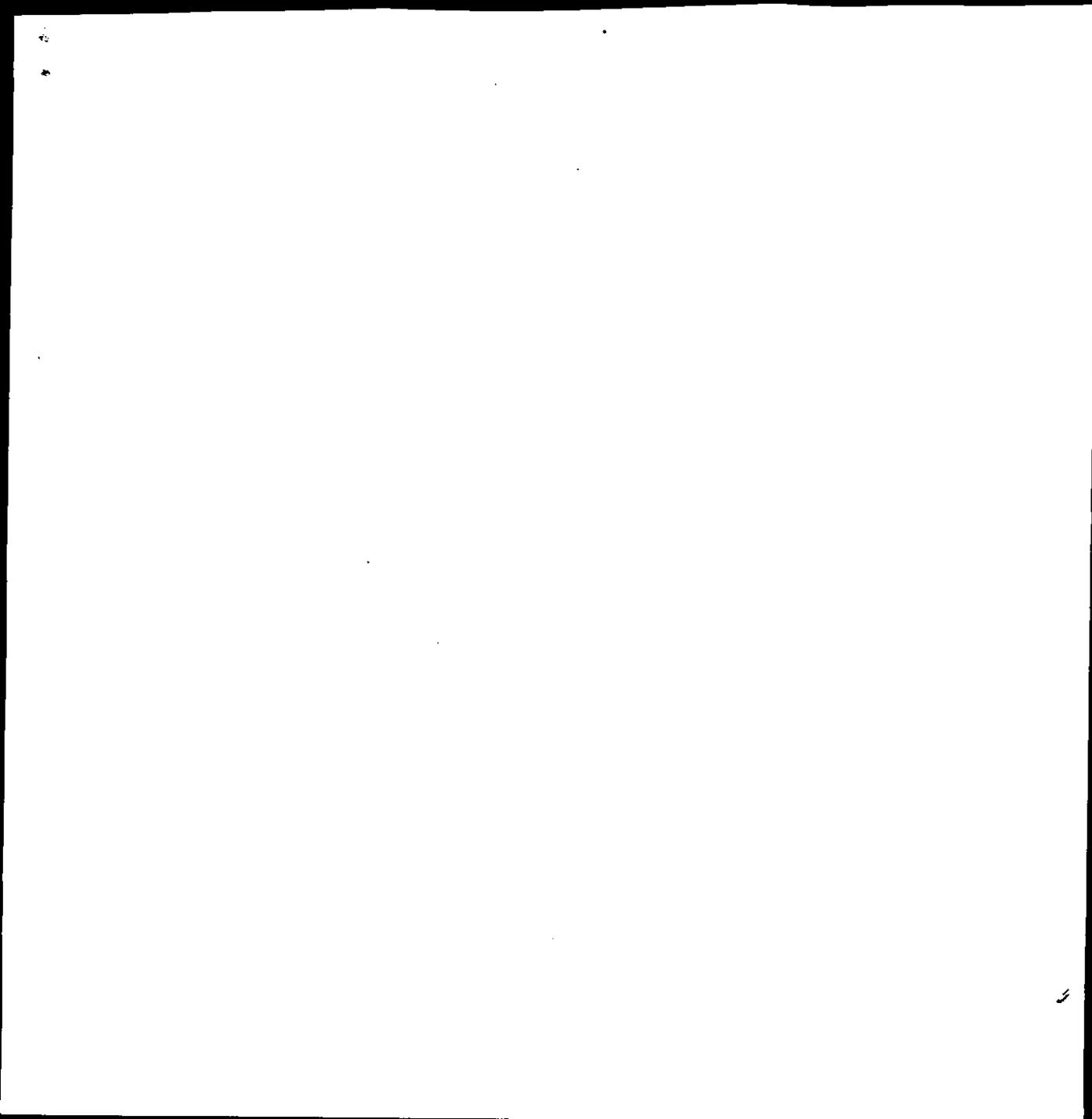
WHAT TEST CONFIRMED DIAGNOSIS? Chemical (Signed) R. H. Fretk, M. D.

3/22, 1930 (Address) Strofford Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mullman Cemetery DATE OF BURIAL 6/21 1919

20. UNDERTAKER J. D. McKerral Acting Undertaker ADDRESS Strofford Mo

PARENTS



RALPH H. FOCHT, M. D.

STRAFFORD, MISSOURI

February 24th, 1930.

State of Missouri.

County of Greene ^{SS}

To whom it may concern.

This is to certify that I attended Thomas Alvin West at the
time of his death on June 20th 1918 at Strafford, Missouri.

Subscribed and sworn to before me
the 24th day of Feb. 1930.

R. H. Focht
or R. H. Focht.

A. D. Givens
Notary Public,

My Com Expires, April 27-1933.

19502-1

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene Registration District No. 944 File No. 2
 Township Jackson Primary Registration District No. 1547 Registered No. 2
 City Stratford Mo. St. _____ Ward _____

2. FULL NAME Thomas Oliver West
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1919

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

17. I HEREBY CERTIFY That I attended deceased from June 17 1919 to June 20 1919
 that I last saw alive on June 20 1919, and that death occurred, on the date stated above, at _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10, 1892

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 2 15

CONTRIBUTORY (SECONDARY) unknown (duration) _____ yrs. _____ mos. 3 ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) D. H. Focht, M. D.
 821930 (Address) Stratford Mo

9. BIRTHPLACE (CITY OR TOWN) Greene Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER John West

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Gitchell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

14. INFORMANT Wm. Will Clouse
 (Address) Stratford Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Walker Cemetery DATE OF BURIAL 6/21/19

FILED 26 1919 W. B. Guier REGISTRAR

20. UNDERTAKER J. D. McReral ADDRESS Stratford Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact hour.

SUPPLEMENTARY

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