LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

11885

PLACE OF DEATH
County Bates — Registration District No. 50 — File No. 156
Township — Primary Registration District No. 3004 — Registered No.
City Butler (No. ..., ... St. ..... Ward)

FULL NAME Agnes Thompson West

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

th 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

EX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	Widowed

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Sam West

ATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 12 - 1851

GE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	72	2	3	

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

IRTHPLACE (CITY OR TOWN) Edinborough Scotland
(STATE OR COUNTRY)

0. NAME OF FATHER Wm McLaughlin

1. BIRTHPLACE OF FATHER (CITY OR TOWN) Scotland
(STATE OR COUNTRY) Scotland

2. MAIDEN NAME OF MOTHER Christina Thompson

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scotland
(STATE OR COUNTRY) Scotland

INFORMANT Mrs Agnes Lee Hill
(Address) Kansas City Mo.

FILED May 9th 1923 T. F. Tockwood
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1923

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Apr 10, 1923 that I last saw her alive on Apr 15, 1923 and that death occurred, on the date stated above, at 7:00 PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

90

Hypocondilis

102 (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) High Blood pressure

(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. M. Chastain, M. D
4/16, 1923 (Address) Butler 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Oak Hill	April 17 1923
20. UNDERTAKER	ADDRESS
Culvers	Butler Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH
County Bates Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. .....
City Butler (No....., ...St. .....

2. FULL NAME Agnes 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15

17. I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at 7:P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
.....
.....
.....
.....(duration).....yrs. .....mos.....

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BUR

20. UNDERTAKER ADDRESS

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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