

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

Do not use this space.

9825

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (No. 2816 Lemps ave)

File No.....
 Registered No. 2586 St. _____ Ward)

2. FULL NAME

Lena Mae West
 (a) Residence. No. 2816 Lemps ave. St. 24 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13 - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 9 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
 (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) Ill.

10. NAME OF FATHER Walter West, Jr.

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

12. MAIDEN NAME OF MOTHER Lena Klump

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

14. INFORMANT Walter West, Jr. (Address) 2816 Lemps ave

15. FILED 10 1927 2816 Lemps ave

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 - 1927

17. I HEREBY CERTIFY That I attended deceased from March 7, 1927 at March 7, 1927 pm that I last saw h. er. alive on March 7, 1927, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11913
Convulsions
 (duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (SECONDARY) gastro-enteritis
 (duration) _____ yrs. _____ mos. 4 ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) Adeline Chatter, M. D. 17, 1927. (Address) 2603 Cherokee St

*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 Sunset Burial Pk. DATE OF BURIAL March 10 1927

20. UNDERTAKER Ziegenhein Bros 2653 Cherokee ADDRESS _____

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.

