

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

Do not use this space.

35179

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....*St. Louis* (No.....)

Registration District No. **791**  
Primary Registration District No. **1003**

File No. ....  
Registered No. **10355**  
St. .... Ward.....

**2. FULL NAME**

*James I. West*

(a) Residence No. *5351 Delmar* St., *12* 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*) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 30 - 1853*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>73</i>	<i>2</i>	<i>18</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *Grassy*  
(STATE OR COUNTRY) *MO*

10. NAME OF FATHER *Simon West*

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

12. MAIDEN NAME OF MOTHER *Mary Douglas*

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

14. INFORMANT *Hilmoth Haller*  
(Address) *5351 Delmar*

15. FILED *NOV 19 1921*  
*Mrs. C. Starkloff*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 18 1927*  
17.

I HEREBY CERTIFY, That I attended deceased from *June 29*, 19*27*, to *Nov 18*, 19*27*, that I last saw him alive on *Nov 17*, 19*27*, and that death occurred, on the date stated above, at *8:45 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*131 Chronic nephritis*  
..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) *1290*  
..... (duration) ..... yrs. .... mos. .... ds.

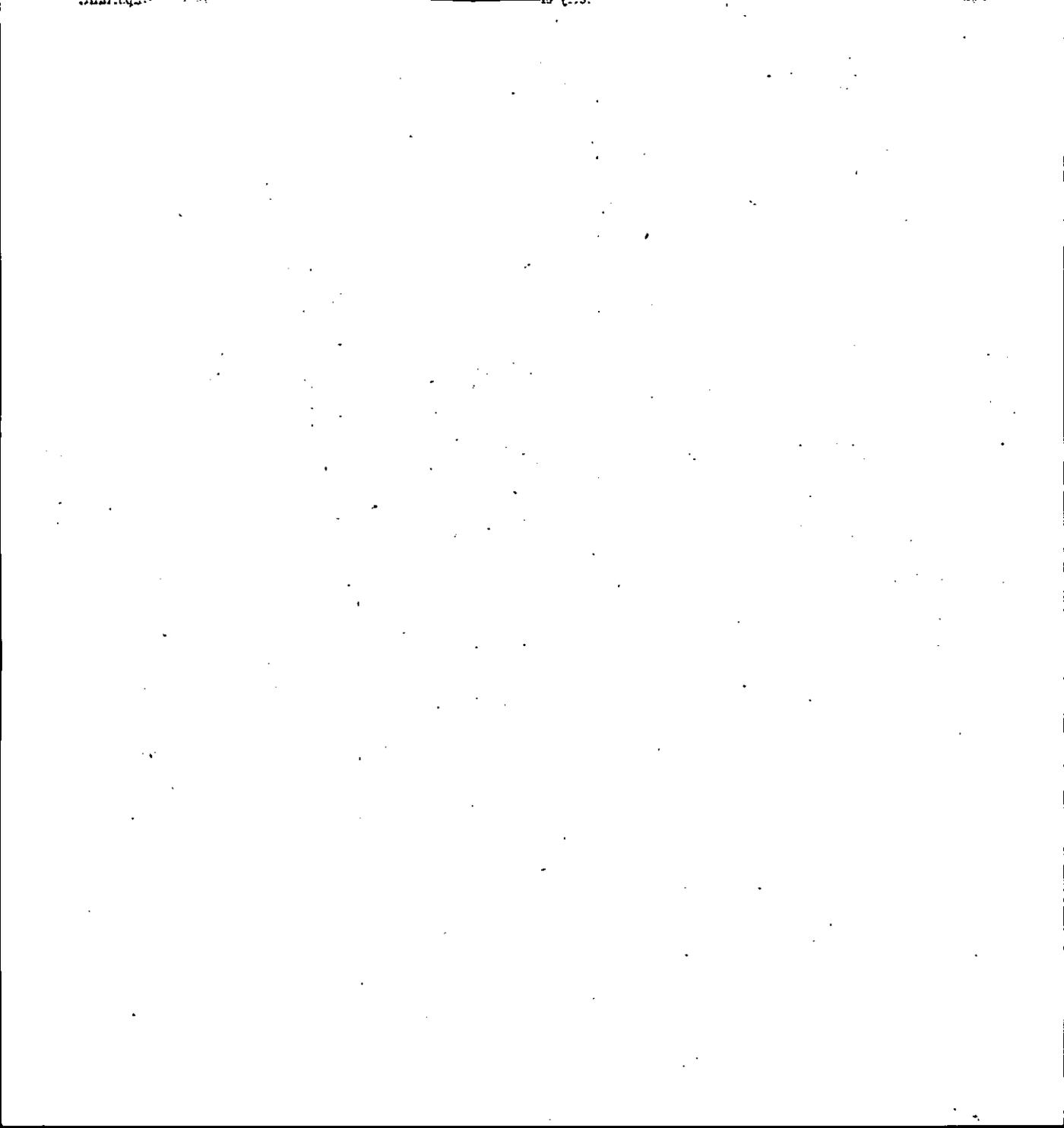
18. WHERE WAS DISEASE CONTRACTED *1290*  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) *D. A. R. J.*, M. D.  
*118*, 19*27* (Address) *Linton Plaza*

\*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 *Valhalla Ceme* DATE OF BURIAL *Nov-19 1927*

20. UNDERTAKER *Alexander & Sons 617 5th Delmar*  
ADDRESS



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 791 File No.....  
 Township..... Primary Registration District No. 1003 Registered No. 103072  
 City St. Louis (No.....) St. 1st (Ward)

**2. FULL NAME**.....

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30 - 1854 (1853)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
X 73 X 2 X 18

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. May 6 1907  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 18 1907

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

.....  
 (duration)..... yrs. .... mos. .... da.

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

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPTSY.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.  
 , 19 (Address)

\*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..... DATE OF BURIAL.....  
 19

20. UNDERTAKER..... ADDRESS.....

**SUPPLEMENTARY**

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 understood. Cause of death statement of OCCUPATION is very important.

S-35179