

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

Do not use this space.

3084

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1605

City St. Louis (No. City 1605) ..... St. 12 Ward) 573

**2. FULL NAME** Thomas N. West

(a) Residence. No. 5748 Ewing St. 12 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 27 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 OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28 - 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>69</u>	<u>8</u>	<u>19</u>	

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER Wm. N. West

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

12. MAIDEN NAME OF MOTHER Marina

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

14. INFORMANT (Address) Edmond City 1605

15. FILED 18, 1937 New C. Standley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1937

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929 to June 16, 1937 that I last saw him alive on June 16, 1937 and that death occurred, on the date stated above, at 6:45 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of Stomach  
 (duration) ..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Aortitis (Luetic)  
Cor. myocarditis  
 (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 5748 Ewing  
 IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Xray  
 (Signed) Ben Margulies, M. D.  
1/17, 1930 (Address) City 1605

\*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 Ms. Creatorium DATE OF BURIAL 1/18 1930

20. UNDERTAKER The Graham Bros. ADDRESS 2621 Cherokee

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.

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