

JUN 24 1930

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

Do not use this space.

15640

1. PLACE OF DEATH  
 County Lefay Registration District No. 201  
 Township Liberty Primary Registration District No. 5980  
 City Newton West (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Newton 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.

File No. \_\_\_\_\_  
 Registered No. 534  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
86

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Labor  
 (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) Dont know

10. NAME OF FATHER Dont know

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT John West  
 (Address) Excelsior Bldg 720

15. FILED 6/10/30 Wm H. Seadon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1930

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_  
Mr, 1930, to May 20, 1930  
 that I last saw him alive on May 18, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
Chronic Bright  
131  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 1290  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 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? none  
 (Signed) Wm H. Seadon M. D.  
5-24, 1930 (Address) Liberty 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 Enon DATE OF BURIAL May 21 1930

20. UNDERTAKER Herbert Hope Springs ADDRESS \_\_\_\_\_

Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE 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.

