

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

Do not use this space.

16324

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. 2605)

Registration District No. 399  
Primary Registration District No. 1002  
Montgal

File No. 2232  
Registered No. 2232  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

George W. West

(a) Residence. No. 2005 Montgal St. 11 Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 11 mos. 11 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 Married  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 2 21

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Carpenter  
(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) Wisconsin

10. NAME OF FATHER James West  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known  
12. MAIDEN NAME OF MOTHER Lewera Wolf  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Mrs Ruth Cox  
(Address) 2605 Montgal

15. FILED 5/26, 1930 M. M. Corone REGISTRAR  
West

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1930

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:**

Cancer Stomach  
46B (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? Yes  
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
(Signed) Stanley M. Wiles M. D.  
5/23, 1930 (Address) Deputy Coroner

\*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 Mt. Moriah Cemetary DATE OF BURIAL 5-26-30, 1930

20. UNDERTAKER J. P. Louis Funeral Director, City. 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.

RECORD

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