

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.

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

Do not use this space.

18453

1. PLACE OF DEATH

County North
Township Witchell
City Grant City, Mo.

Registration District No. 903
Primary Registration District No. 6545

File No. _____
Registered No. 17
St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

Josie Carroll West

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

Nov. 25 1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.

68

6

6

8. OCCUPATION OF DECEASED

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

Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employee)

Line repair operator

(c) Name of employer

P.C. Telephone Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

North
Mo.

10. NAME OF FATHER

Marion A. West

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

North
Ohio

12. MAIDEN NAME OF MOTHER

Lidia Kipp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

North
Ohio

14.

INFORMANT

(Address)

Carroll West
Sheridan, Mo.

15.

FILED

6/1, 19

John Anderson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 31 1930

17.

I HEREBY CERTIFY, That I attended deceased from
May 31, 1930, to May 31, 1930,
that I last saw him alive on _____, 19____, and that
death occurred, on the date stated above, at _____ m.
1930. THE CAUSE OF DEATH* WAS AS FOLLOWS:

1945 fractured skull
accidental, fell from
telephone pole to the ground
city Mo. (duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY) fell from telephone
pole (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? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) _____

Phys. Findings _____, M. D.

6/1, 1930 Address) Grant City,

*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

Sheridan, Mo.

6/4 1930

20. UNDERTAKER

ADDRESS

Arch C. Dunfee

Grant City

