

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

Do not use this space.

1298

129

1. PLACE OF DEATH

County Jackson
Township 1st
City K. C. Mo. (No. St. Joseph Hospital)

Registration District No. 393
Primary Registration District No. 1002

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

2. FULL NAME Thomas Edward West

(a) Residence. No. 2220 Chelsea 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

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 Addie West

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-11-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 4 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own Farm
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Henry West

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Julia Pool

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. Addie West

(Address) 2220 Chelsea Ave

15. FILED 1-10-31 M M Crowe

REGISTRAR W. J. Foster

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-8-1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1931, to Jan 8 1931, that I last saw him alive on Jan 8 1931, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia

CONTRIBUTOR (SECONDARY) Pneumococcus Infection

18. WHERE WAS DISEASE CONTRACTED 107

IF NOT AT PLACE OF DEATH 2220 Chelsea

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) T. C. Cunniff M. D.

1-9-1931 (Address) 6520 Ind. Ave

*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 Mo. Labor Mo. DATE OF BURIAL Jan-10-1931

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. Mo.

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.

WITH IMPROVING INK—THIS IS A PERMANENT RECORD

Jr. W. B.

6520 Lnde Be-0756

805 Newton 0042

4:30 p m.