

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

Do not use this space.

14047

**1. PLACE OF DEATH**

County Ray  
Township Wright  
City Wright Mo.

Registration District No. 398  
Primary Registration District No. 5554

File No. \_\_\_\_\_  
Registered No. 164  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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) Jan. 76 - 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 12 hrs. or min. 159

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Wright  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Clarence West

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

12. MAIDEN NAME OF MOTHER Shelby McDowell

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

14. INFORMANT Clarence West  
(Address) Birmingham

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 27 1931

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1931, to April 26, 1931, that I last saw her alive on April 26, 1931, and that death occurred, on the date stated above, at 7 PM m.

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

Premature birth - 8 mos  
159 / 59 (duration) yrs. mos. 12 hrs  
CONTRIBUTORY Fall 24 hrs previous (SECONDARY) (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. no  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? yes  
(Signed) Russell J. Hodge, M. D.  
4-27, 1931 (Address) North Kansas City 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 Co. of Amherst DATE OF BURIAL 4-28 1931

20. UNDERTAKER Wright ADDRESS Wright 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. MAY 29 1931.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Jackson Registration District No. 398 File No. \_\_\_\_\_  
 Township Blaine Primary Registration District No. 3154 Registered No. 164  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Dora Dell 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.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word) S.

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 19 31

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

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date above, at \_\_\_\_\_ m.

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

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

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

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

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 \_\_\_\_\_ (Address) \_\_\_\_\_

\*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.

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

15. FILE June 19 31 F. L. BOOK REGISTER

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

WITH OBTAINING INK--THIS IS A  
 INFORMATION should be carefully supplied. AGE should be stated.  
 H in plain terms, so that it may be properly classified. Exact statement  
 SHALL NOT RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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