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

Do not use this space.

18495

1. PLACE OF DEATH

County Vernon — Registration District No. 875 — File No.

Township Washington — Primary Registration District No. 6162 — Registered No. 129

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Chas. E. West

(a) Residence. No. State Hospital #2 St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 4 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 (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 16/1867

7. AGE: Years 65 — Months 3 — Days 30 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Machinist (R.R.) 60
(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): ~~Carthage Bal Co.~~ Mo. 1

PARENTS

10. NAME OF FATHER: W. H. West
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill. 2
12. MAIDEN NAME OF MOTHER: Jennie Wiles
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo 1

14. INFORMANT: May West, (Address) 714 S. Ave. Springfield

15. FILED 6-15, 1932 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 15 1932

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1931, to May 15, 1932, that I last saw him alive on ....., 1932, and that death occurred, on the date stated above, at 4-10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

108 (duration) ..... yrs. ..... mos. 8 ds.

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

18. WHERE WAS DISEASE CONTRACTED (1)

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) T. T. O'Dell, M. D

May 15, 1932 (Address) Nevada, 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: Springfield Mo — DATE OF BURIAL: 5/16 1932

20. UNDERTAKER: Alley O Hays — ADDRESS: Nevada Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

V. S. NO. 27