

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

Do not use this space.

37634

**1. PLACE OF DEATH**

County..... Registration District No.....  
 Township..... Primary Registration District No.....  
 City St. Louis, Mo (No. City Hospital #2)

File No.....  
 Registered No. 10312  
 St..... Ward.....

**2. FULL NAME**

Thomas West  
 (a) Residence, No. 2839 Hamble St. W. Ward.....  
 (Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-20-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
52 5 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Subv  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

FATHER 13. NAME Coleman West

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Name Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) A Supt. Death City Hosp #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickson DATE Nov. 22, 1932

19. UNDERTAKER (ADDRESS) P. V. Atkins 2331 N. Morgan St.

20. FILED NOV 22 1932 Max C. Starker Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-19-1932

22. I HEREBY CERTIFY, That I attended deceased from 9-29, 1932, to 11-19-32, 1932.  
 I last saw him alive on 11-19-32, 1932. Death is said to have occurred on the date stated above, at 12:00 m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis  
17A  
 Other contributory causes of importance: PB

Name of operation..... Date of.....  
 What test confirmed diagnosis? Alm & Del Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Smith, M. D.  
 (Address) City Hospital #2

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.

