

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.

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

Do not use this space.

SEP 27 1934

1. PLACE OF DEATH  
 County McDonald Registration District No. 1167  
 Township Elkhorn Primary Registration District No. 5698  
 City Stella, Mo. (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2. FULL NAME William T. 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.

File No. 25416  
 Registered No. 20

**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 Sarah West

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3 - 1859

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>75</u>	<u>1</u>	<u>10</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farmer  
 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) Texas

MOTHER FATHER  
 13. NAME Thomas West  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn  
 15. MAIDEN NAME Stanley  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT Sarah West  
 (ADDRESS) Stella, Mo. R2

18. BURIAL, CREMATION, OR REMOVAL PLACE Wesley Cemetery DATE July 14, 1934

19. UNDERTAKER Chas. W. Williams  
 (ADDRESS) Stella, Mo.

20. FILED Aug. 14, 1934 Acta Callings  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 13, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 8, 1934, to July 13, 1934.  
 I last saw him alive on July 8, 1934. Death is said to have occurred on the date stated above, at 10 a. m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage  
 Other contributory causes of importance: \_\_\_\_\_  
 Date of onset July 8 - 1934

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) J. R. [Signature], M. D.  
 (Address) Stella, Mo.

