

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

Do not use this space.

543

1. PLACE OF DEATH

County Cass

Registration District No. 156

Township _____

Primary Registration District No. 4090

City Harrisonville (No. _____)

St. _____ Ward _____

2. FULL NAME Owelle West Jr.

(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 1 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 Black 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 21 - 1930

7. AGE YEARS 6 MONTHS _____ DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child in school

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) Johnson Co Mo.

13. NAME Viola Owelle West

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

15. MAIDEN NAME Labell Turner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co.

17. INFORMANT (ADDRESS) Viola West Mo. Harrisonville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Holden Mo. DATE Jan 23 1936

19. UNDERTAKER (ADDRESS) Reunertburgers Harrisonville Mo.

20. FILED Jan 22 1936 W. M. Griffith Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22, 1936

I HEREBY CERTIFY That I attended deceased from Jan 21, 1936 to Jan 22, 1936

I last saw him alive on Jan 21, 1936 Death is said to have occurred on the date stated above, at 7:45 A.M.

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

Other contributory causes of importance _____

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 _____

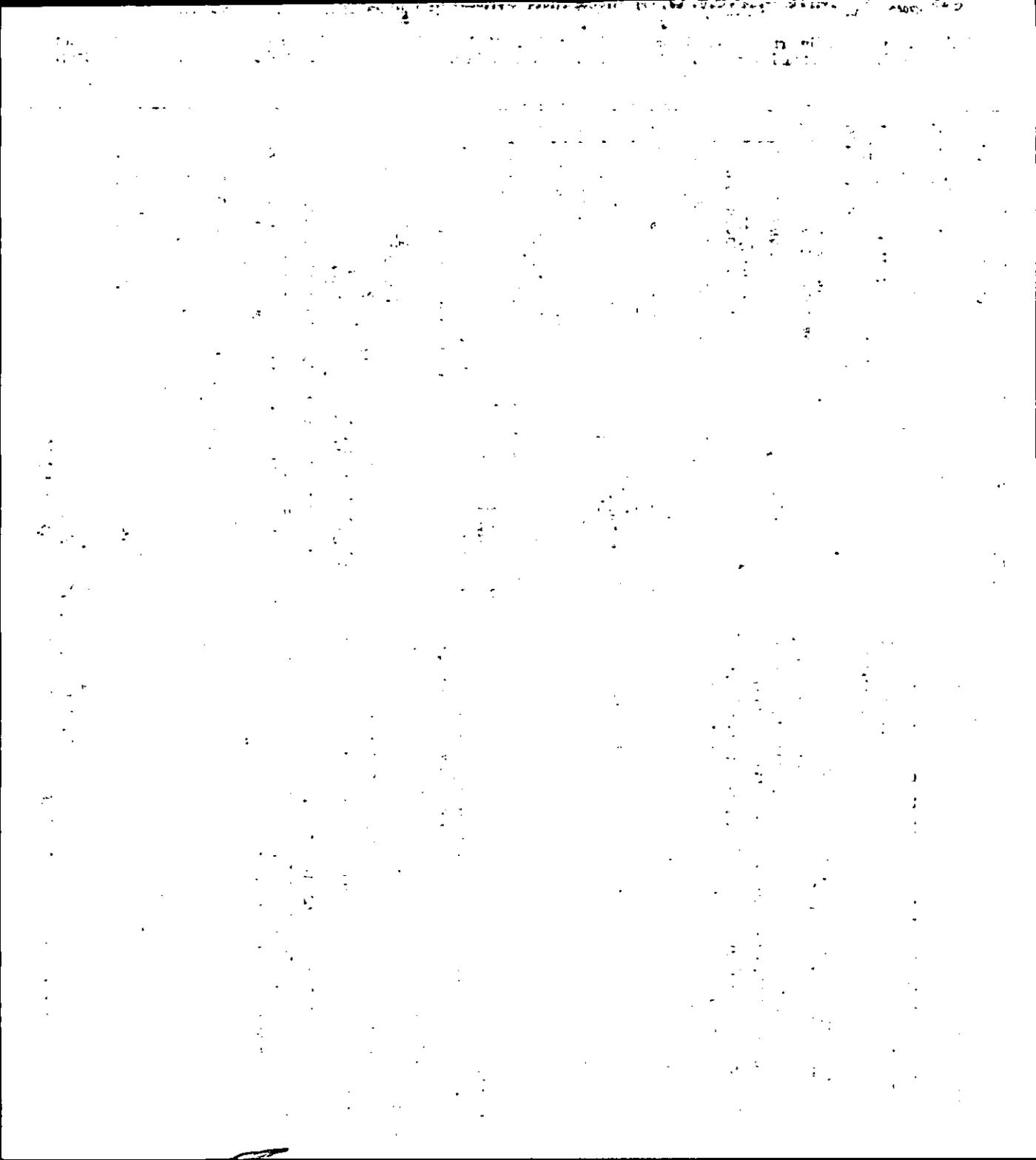
24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) E. M. Gaffler M. D.

(Address) Harrisonville 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.



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

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1. PLACE OF DEATH

County Wes

Registration District No. 15-6

File No.

Township

Primary Registration District No. 4090

Registered No.

City Harrisonville

St. Ward)

2. FULL NAME

Owella West Jr

(a) Residence, No. St. Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

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

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

7. AGE YEARS 6 MONTHS - DAYS 1 If LESS than 1 day, 4 hrs. or 1 min.

8. Trade, profession, or particular kind of work done, as splainer, sawyer, bookkeeper, etc.....
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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Feb 13, 1936 E M Griffith Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22, 1936

22. I HEREBY CERTIFY, That I attended deceased from

I last saw alive on, 19..... Death is said

to have occurred on the date stated above, at.....m.

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

Bronchial pneumonia Date of onset

Other contributory causes of importance:

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) E. M. Griffith M. D.

(Address) Harrisonville Mo

SUPPLEMENT

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.

WRITE PLAINLY IN INK—THIS IS A PERMANENT RECORD

S-543