

JAN 19 1938

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson
Township Warrens
City Keokuk (No. _____) St. _____ Ward _____

Registration District No. 469
Primary Registration District No. 555-8

File No. ~~45620~~
Registered No. 792

2. FULL NAME

Charles Edwin West 230

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 27-1854

7. AGE YEARS 83 MONTHS 11 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as printer, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. General farm
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) Salisbury (STATE OR COUNTRY) Pa

MOTHER 13. NAME Thomas West

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

15. MAIDEN NAME Nancy McHarrity

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

17. INFORMANT Bela Mae (ADDRESS) Hance City Mo RD 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Independence Cemetery DATE _____ 19

19. UNDERTAKER T. W. McConnell Son (ADDRESS) Hance Mo

20. FILED 1-9- 1938 Mrs J. J. Brennan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 5 1938

22. I HEREBY CERTIFY That I attended deceased from Jan 1 1938, to Jan 5 1938

I last saw him alive on Jan 1 1938. Death is said to have occurred on the date stated above, at 10:30 P.M.

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

Cerebral Hemorrhage Date of onset _____

Other contributory causes of importance: _____

Name of operation home Date of _____
What test confirmed diagnosis? clinical 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) R. F. Barman M. D.
(Address) Wester City

100

[Redacted]

THE [Redacted] [Redacted] [Redacted]

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

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Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township Washington
(c) City

Registration District No. 404
Primary Registration District No. 5558

Registered No. 18

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Perkins - wid

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 83 1 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. general farm & horse raising
10. Date deceased last worked at this occupation (month and year) 1925 11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Curran Ill

13. NAME Thomas West

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

15. MAIDEN NAME Nancy McCallough

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

17. INFORMANT (ADDRESS) S

18. BURIAL, CREMATION, OR REMOVAL PLACE Smiths Chapel DATE Jan 7 - 1938

19. FUNERAL DIRECTOR (ADDRESS) Ray McConnel Home Mo

20. FILED 4-1 1938 Mr J J Brunner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 5, 1938

22. I HEREBY CERTIFY, that I attended deceased from Jan 1 - 1938, to Jan 5 - 1938.
(I last saw him alive on Jan 1, 1938. 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:

Central Apoplexy -
reflex Spasms
with hypertension
Date of onset Jan 1, 1938

Other contributory causes of importance:
reflex Spasms with hypertension

Name of operation none Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 1 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) B. F. Bramand, M. D.
(Address) Martin City Mo

