

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

662  
Do not use this space.

REC'D FEB 10 1939

1. PLACE OF DEATH 791

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No. **1003** Registered No. **662**

(c) City **St. Louis, Missouri** (d) Street No. **City Sanitarium** St.

(e) Length of residence in city or town where death occurred **18** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Howard West**

(a) Residence, No. **2166 Lafayette Ave.** St. **23** (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-9-1909**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<b>29</b>	<b>7</b>	<b>13</b>	

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-21-39** 19

22. I HEREBY CERTIFY, That I attended deceased from **July 1, 1938**, 19....., to **1-21-39**, 19.....

I last saw him alive on **1-21-39**, 19..... Death is said to have occurred on the date stated above, at **1:45 A.M.**

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Chauffeur**

9. Industry or business in which work was done, as saw mill, bank, etc. **Film Del**

10. Date deceased last worked at this occupation (month and year) **April 1931**

11. Total time (years) spent in this occupation.....

**Pulmonary Edema - cause unknown**  
**Acute Cardiac Failure, no definite disease of heart**

Date of onset

Other contributory causes of importance: **11/16**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Illinois**

13. NAME **Charles West**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Illinois**

15. MAIDEN NAME **Delta Morton**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Kentucky**

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **Yes**

17. INFORMANT **W. Kousler 718** (ADDRESS) **5400 Grand**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Matthews** DATE **1-23** 19

19. FUNERAL DIRECTOR (NAME) **H. W. McLaughlin** (ADDRESS) **2301 Lafayette**

20. FILED **JAN 22 1939** **J. B. Bredt** Local Registrar.

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) **W. Kousler**, M. D.  
(Address) **City Sanitarium**

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

*L. H. Cooper*

or by

Registered Apprentice No. ...., working under my personal supervision.

Signed

*L. H. Cooper*

Licensed Embalmer No.

*3633*

P. O. Address

*2317 Lafayette*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**