

DESD FEB 16 1939

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

2368
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 320
(b) Township W. 2 Primary Registration District No. 5443
(c) City _____ (d) Street No. _____ St.
(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 William E. West.

(a) Residence, No. Bois D'Arc. Missouri R.D. # 1st. (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 Male. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widower
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-11 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 4 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Red 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) Greene Co, Mo

13. NAME Joseph West

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

15. MAIDEN NAME Angeline Mason

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

17. INFORMANT (ADDRESS) Mrs. Pearl K. Coffman
Bois D Arc

18. BURIAL, CREMATION, OR REMOVAL PLACE Prospect Burial DATE 2/5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Will Kern & Son
Bois D Arc Mo

20. FILED 2/4 1939 Luzyle Howard
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1st 1939

22. I HEREBY CERTIFY, That I attended deceased from January 18 1939 to February 1st 1939
I last saw h. in alive on February 1st 1939. Death is said to have occurred on the date stated above, at 2:15 m. P.M.
The principal cause of death and related causes of importance were as follows:

Coronary Bloc.
Myocardial degeneration.
A 2 C

Other contributory causes of importance: following an attack of influenza.

Name of operation None. Date of None.
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? N.O. 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? NO.
If so, specify _____ (Signed) Charles H. Mykoffie, M. D.
271 (Address) Ash Grove, Missouri.

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

Signed J. Birch

Licensed Embalmer No. 3856

P. O. Address Park Grove No

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.