

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

14929
Do not use this space.

1939 MAY 11 1939

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township Campbell Primary Registration District No. 5440
 (c) City SPRINGFIELD or SPRINGFIELD Registered No. 324
 (d) Street No. A.P. 7 Springfield 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

MINNIE ALICE WEST
 (a) Residence, No. A-7 Springfield mo St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the ward) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 24-1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
52 1 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 9. Industry or business in which work was done, as 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) Bois d'arc mo

FATHER 13. NAME Andrew a. west

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bois d'arc mo

MOTHER 15. MAIDEN NAME Sarah C. Hammond

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

17. INFORMANT (ADDRESS) Hugh west A-7 Springfield

18. BURIAL, CREMATION, OR REMOVAL PLACE Brookline DATE 4-16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dunn-Hall Springfield mo

20. FILED Apr 16 1939 Chas W George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 21 1939, to Apr 3 1939

I last saw her alive on Apr 3 1939 Death is said to have occurred on the date stated above, at 9:15 A.M.
 The principal cause of death and related causes of importance were as follows:

Pernicious Anemia Date of onset

Other contributory causes of importance: Jacuz Psychosis Feb 1939

Name of operation None Date of None
 What test confirmed diagnosis Examination 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

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) J. A. Payne M. D.

(Address) James Blay Springfield mo

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, or by.....

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

Signed *Thyrd W. Ford*
Licensed Embalmer No. *2910*
P. O. Address *629 W Walnut*

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.

X