

REC'D JUN 19 1939

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

20078  
Do not use this space.

1. PLACE OF DEATH

(a) County Webster Registration District No. 896  
(b) Township S. Grant Primary Registration District No. 6199  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
(e) Length of residence in city or town where death occurred life yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

James Franklin West  
(a) Residence, No. \_\_\_\_\_ 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Laura Belle West  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 29, 1860  
7. AGE YEARS 78 MONTHS 8 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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. Farm  
10. Date deceased last worked at this occupation (month and year) 1928 11. Total time (years) spent in this occupation life  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
13. NAME Jerry ?  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
15. MAIDEN NAME ? Warden  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
17. INFORMANT (ADDRESS) Clarence West  
Strafford, Missouri  
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Pisgah DATE May 18, 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rex Rainey  
Marshfield, Missouri  
20. FILED May 27, 1939 Elizabeth Highler  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17, 1939  
22. I HEREBY CERTIFY, That I attended deceased from May 9, 1939, to May 15, 1939  
I last saw him alive on May 9, 1939 Death is said to have occurred on the date stated above, at 8 A. M.  
The principal cause of death and related causes of importance were as follows:  
Myocardial degeneration Date of onset ?  
Other contributory causes of importance: 93C  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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? No  
If so, specify \_\_\_\_\_  
(Signed) R. A. Focht M.D.  
(Address) Strafford Mo.

WHILE I EXAMINE WITH REGARDING INFORMATION 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.

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RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1310

Date Filed JUN 13 1939

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**