

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

33354
Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 750
 (b) Township _____ Primary Registration District No. 5985
 (c) City or Town Doniphan (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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary L. West (Deceased)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 5 1853

7. AGE YEARS 82 MONTHS 2 DAYS 19 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 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. 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) Green Co. Kentucky

FATHER 13. NAME Bob West

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Co. Kentucky

MOTHER 15. MAIDEN NAME Sarah Legston

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Co. Kentucky

17. INFORMANT (ADDRESS) Mrs. H. F. Rockett Doniphan Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Olive Cem. DATE 9-25-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Black's Mortuary Doniphan Mo.

20. FILED 9-25-39 E. B. Johnston Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-1 ¹⁹³⁷ to Sept 24 1939
 I last saw him alive on July 1 1939 Death is said to have occurred on the date stated above, at 8:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Date of onset unknown
Cerebral Hemorrhage
 Other contributory causes of importance: hypertension

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? _____

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) Clifford G. Goforth M. D.
 (Address) Doniphan 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.

I X16805

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.....

worked under my personal supervision.

RECEIVED
District Health Officer No. 5,

District File Number 1029331

Date Filed 10/12/39

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.