

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. **791**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **St Louis** (b) City or town **St Louis**

(c) Name of hospital or institution **St. Rose Thomey Pulley**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **All life** (Specify whether In this community years, months or days) **56-1-14**

3. (a) PRINT FULL NAME **Charles A. West**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **497-09-9042**

4. Sex **male** 5. Color or race **C**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **Dead** years **20** (Day) (Year)

7. Birth date of deceased **Sept 20 1883**
(Month) (Day) (Year)

8. AGE: Years **56** Months **1** Days **12** If less than one day hr. min.

9. Birthplace **Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Janitor**

11. Industry or business _____

12. Name **George W. West**

13. Birthplace **Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Fannie M. Foster**

15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Small**

(b) Address **2631 Market Pl**

17. (a) **Burial** (b) Date thereof **Nov 7 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Peters**

18. (a) Signature of funeral director **J. W. Hughes**

(b) Address **2620 Lawton**

19. (a) **NOV 7 1939** (b) **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **1**

(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **2752 Goodfellow**
(If rural, give location)

(e) If death born here in U.S.A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **2**
year **1939** hour **7** minute **30 P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **Coronary Occlusion**

Due to **Coronary Occlusion**

Other conditions (Include pregnancy within 5 months of death) _____

Major findings: Of operations **CH**

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

23. Signature **Joseph M. ...** (M. D. or other)

Address **...** Date signed _____

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

Lyda Hughes

Licensed Embalmer No. *2938*

P. O. Address *St Louis mo*

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.