

FILED

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

15907

Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 751
(b) Township Spring Primary Registration District No. 5990
(c) City Rural (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

Alvin Ferdinand Wescoat
(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 <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah L. Wescoat</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 6, 1901</u>		
7. AGE YEARS <u>38</u>	MONTHS <u>5</u>	DAYS <u>25</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Francis Mo.</u>		
13. NAME <u>James Wescoat</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
15. MAIDEN NAME <u>Margaret O'Bannon</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nobby Mo.</u>		
17. INFORMANT <u>Sarah Wescoat</u> (ADDRESS) <u>Mo. Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Memorial Park</u> DATE <u>3-3</u> 19 <u>40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Missie Fish</u> <u>Mo. Mo.</u>		
20. FILED <u>3/4</u> 19 <u>40</u> <u>H. E. White</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 1 1940 19

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:00 A.M.
The principal cause of death and related causes of importance were as follows:

Gun shot wound left chest.

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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)
major mo.

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? _____

If so, specify _____

(Signed) Clifford H. White M. D.(Address) Doniphan Mo.

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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.

District Health Officer No. 5,

District File Number 440 491

Date Filed 4-24-62

Signed B. C. MacLeod

Licensed Embalmer No. 4879

P. O. Address Waverly, Ma

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15907

Registration District No. 757

Primary Registration District No. 5996

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Roskley
- (b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Alvin Ferdinand Westcott

- 3. (b) If veteran, name war _____
- 3. (c) Social Security No. _____

- 4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
- 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
- 7. Birth date of deceased _____ (Month) (Day) (Year)

- | | | | | |
|---------|--------------------|--------------------|-------------------|---------------------------------|
| 8. AGE: | Years
<u>38</u> | Months
<u>5</u> | Days
<u>25</u> | If less than one day _____ min. |
|---------|--------------------|--------------------|-------------------|---------------------------------|

- 9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
- 10. Usual occupation _____
- 11. Industry or business _____
- 12. Name _____
- 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
- 14. Maiden name _____
- 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

- 16. (a) Informant _____ (b) Address _____
- 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
- (c) Place: burial or cremation _____
- 18. (a) Signature of funeral director _____ (b) Address _____
- 19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____ (If outside city or town limits write "RURAL")
- (d) Street No. _____ (If rural, give location)
- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Mar day 1 year 1940 hour _____ minute _____ M.
- 21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

- Immediate cause of death gun shot wound left chest
- Due to _____
- Due to _____
- Other conditions _____ (Include pregnancy within 3 months of death)
- Major findings: Of operations _____
- Of autopsy _____

Duration

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) murder
 - (b) Date of occurrence _____
 - (c) Where did injury occur? Home (City or town) _____ (County) _____ (State) _____
 - (d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place) _____ (c) Means of injury _____
- 23. Signature Clifford Roberts (M. D. or other) _____ Address Doniphan mo Date signed _____

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

