. No. 2
-11-10-39
5-17-39
I X21492

8

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18671

JUN 17 1940

Registration District No. 399 404 Primary Registration District No. 1002 5558 Registrar's No. 2[illegible]

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8444 Wornell Road 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 2 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 8444 Wornall Road
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Ethel Limes West 230

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Winfield Eugene West

6. (c) Age of husband or wife if alive ---------- years

7. Birth date of deceased Oct. 11 (Month) 1890 (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	49	7	12	hr. min.

9. Birthplace No record (City, town, or county) (State or foreign country)

10. Usual occupation Invalid

11. Industry or business

FATHER
12. Name ------- Teeter
13. Birthplace No record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ella Smith
15. Birthplace Norecord (City, town, or county) (State or foreign country)

16. (a) Informant Chester Freeman
(b) Address Wichita Kas.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 25 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address (918 Brooklyn Kansas City Mo.

19. (a) May 25, 1940 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1940 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw the alive on ..... 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia

Due to Internal hydrocephalus

Due to (cause unknown)

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)
(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) Means of injury

23. Signature [signature] (M. D. or other)
Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K.C. 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.

S. No. 2B
—2-21-40
I 62859

WENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18671

Registration District No. 404 Primary Registration District No. 5358 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) ~~City or town~~ Washington T.P.
(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 2 yrs
years, months or days)

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.

3. (a) PRINT FULL NAME Ethel Lines West.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Winfield West

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased Oct (Month) 11 (Day) 1940 (Year)

8. AGE: Years 49 Months 7 Days 12 If less than one day hr. min.

9. Birthplace no record (City, town, or county) (State or foreign country)

10. Usual occupation Invalid

11. Industry or business Foster

FATHER
12. Name Foster
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ella Smith
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Chester Freeman
(b) Address Wichita Kan

17. (a) cremation (Burial, cremation, or removal) (b) Date thereof 5/23/40 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Mrs C. L. Forster
(b) Address 918 Brooklyn K.C. Mo

19. (a) 7-5-40 (Date received local registrar) (b) Mrs Jos. T. Brennan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23 year 1940 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Bronchi Pneumonia — Duration

Due to Internal hydrocephalus (Cause unknown)

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Victor B. Buhler (M. D. or other)
Address K.C. Mo. Date signed

SUPPLEMENTARY