

Registration District No. 944

Primary Registration District No. 5447-B

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Strafford, Mo.  
(c) Name of hospital or institution:  
Strafford Route #  
(d) Length of stay: In hospital or institution not hospitalized  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Rural  
(d) Street No. S.E. of Strafford, Mo.  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12  
year 1940 hour 8 minute a. M.  
21. I hereby certify that I attended the deceased from Jan  
22, 1940 to March, 1940;  
that I last saw her alive on March, 1940  
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Cerebral Hemorrhage

Due to Arterio-sclerosis

Due to Senility

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
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? \_\_\_\_\_  
(e) While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
28. Signature R. M. White (M. D. or other) \_\_\_\_\_  
Address Greene County Date signed 6/15/40

3. (a) PRINT FULL NAME Mealia West 230

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife E.P. West 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 18, 1861  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 24 If less than one day hr. \_\_\_\_\_ min. 0

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

10. Usual occupation Housewife 9

11. Industry or business XXXX 9

12. Name Yancey Green Hester 9

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

14. Maiden name Isabel Caynor

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

16. (a) Informant Finbey West  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof June 15, 1940  
(c) Place: burial or cremation Shiloh Cem.

18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.

19. (a) June 15-40 (b) Harry Guer  
(Date received by Registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

Greene County Health Office,

County File Number 40-7-46

Date Filed 7-10-40

June 15

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 Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield, 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.