

Registration District No. 725

Primary Registration District No. 4431

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

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Center, Mo.
(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 all lifetime (Specify whether years, months or days)

3. (a) PRINT FULL NAME JULIA ANN WEST 230

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband Thomas P. West 6. (c) Age of husband 79 years

7. Birth date of deceased June 7 1860 (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Peter H. Shulsen

13. Birthplace Nichols County - Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Ruth Sears

15. Birthplace Nichols County - Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eliza West

(b) Address 107 Madison, Iowa

17. (a) Burial (b) Date thereof Aug. 3, 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Olivet Cemetery

18. (a) Signature of funeral director Schleker - Couch

(b) Address Center, Mo.

19. (a) 8/10/40 (b) Frank P. Kern (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls
(c) City or town Center (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 Aug. day 1 year 1940 hour 3 minute 30 p.m.

21. I hereby certify that I attended the deceased from July 13, 1940, Aug. 1, 1940; that I last saw her alive on Aug. 1, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis (chronic) Duration 5 yrs

Due to unknown

Due to unknown

Other conditions none (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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? _____

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

23. Signature C. H. Brooke (M. D. or other) Dr.

Address Center, Mo. Date signed 8-2-40

RECEIVED

District Health Officer No. 10

District File Number 8-40-1668

Date Filed Aug 21 1940

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

Edgar B. Schlanter

Licensed Embalmer No.

4136

P. O. Address

Center, Missoula

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.