

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41457**
Registrar's No. **4850**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **54 years**
(Specify whether
In this community **Life**
years, months or days)

8. (a) PRINT FULL NAME **GEORGE WESTFALL**

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

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Grace Westfall** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **May 19 1886**
(Month) (Day) (Year)

8. AGE: Years **54** Months **7** Days **0** If less than one day hr. min.

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

10. Usual occupation **Insurance**

11. Industry or business _____

MOTHER-FATHER { 12. Name **Geo. W. Westfall**

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

14. Maiden name **Lovenia I. Belt**

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

16. (a) Informant **Grace Westfall**

(b) Address **2208 E. 72**

17. (a) **Burial** (b) Date thereof **Dec. 21 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn 12-21-40**

19. (a) **12-21-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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. **2208 E. 72nd St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **19th**
year **1940** hour **7** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **12-14-40**, 19____, to **12-19-40**, 19____;
that I last saw him alive on **12-19-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia**

Due to **Acute and chronic pulmonary edema and congestion; Hypertrophy and Dilatation of Heart**

Due to **95 113**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations: _____

Of autopsy **See above**

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) _____
(e) Means of injury _____

23. Signature **Henry R. Thoren** (M. D. or other) _____
Med. Dir. K.C. Gen. Hospital
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Gerald T. Wade

Licensed Embalmer No. 4172

P. O. Address K. E. 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.