

2
40
7-39
X23159

REC JAN 13 1949

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42350

Registration District No. 263

Primary Registration District No. 5365

Registrar's No.

1. PLACE OF DEATH:

(a) County De Kalb

(b) City or town Weatherbury - rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
farm home (Adams)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 15 years
years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb

(c) City or town Rural Adams Twp,
(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.? Native years.

3. (a) PRINT FULL NAME Joseph Madison West

3. (b) If veteran, name war _____

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17
year 1940 hour 6:30 minute 0? M.

4. Sex male

5. Color or race White

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

6. (b) Name of husband or wife Sarah

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

7. Birth date of deceased Jan 2 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 15
March 1940 to Dec-17 1940
that I last saw him alive on 8th Dec- 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 11 Days 14 hr. min.

Immediate cause of death apoplexy

Due to _____

Due to stroke

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

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name Emory West

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

14. Maiden name Matheline Bowen

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

Major findings: none

Of operations _____

Of autopsy none

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Kenneth Mann

(b) Address Winston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-40
(Month) (Day) (Year)

(c) Place: burial or cremation Winston, Mo.

18. (a) Signature of funeral director J. E. Daniel

(b) Address Weatherbury, Mo.

19. (a) Jan 1949 (Date received local registrar) (b) James Fitzgerald (Registrar's signature)

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? 221

While at work? no (Specify type of place) (e) Means of injury none

23. Signature M. S. Dale (M. D. or other) _____

Address Osborn Mo Date signed 12/17/40

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

Registered Apprentice No.

working under my personal supervision.

Signed

Geo. E. Daniel

Licensed Embalmer No.

3900

P. O. Address

Weatherbury, Md.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42350

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 263

Primary Registration District No. 5365-

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County DeKalb
 (b) City or town Adams
 (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 _____ (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME Joseph Newton West

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 _____ year

7. Birth date of deceased Jan 21 1872
 (Month) (Day) (Year)

8. AGE: 68 Months 11 Days 14 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 13-41 (b) Jamaar Fitzgerald
 (Date received local registrar) (Registrar's signature)

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.

DECLARATION OF DEATH

20. DATE OF DEATH Month Dec day 14
 year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 W. S. Gale _____ (M. D. or other)

Address DeKalb _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

