

FILED JAN 22 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

44124

1. PLACE OF DEATH

County Texas Co Registration District No. 1843
Township Ozark Primary Registration District No. 10141
City Emminger No. 2 St. _____ Ward _____

File No. _____

Registered No. 9

2. FULL NAME

(a) Residence, No. Texas Co and Rural (If nonresident, give city or town and State)Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Job Nelson West

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

April 27 18597. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
89 7 1

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

At Home

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Daton Ohio

13. NAME

Francis R. Nagle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Germany

15. MAIDEN NAME

Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Don't Know

17. INFORMANT (ADDRESS)

Albert West

18. BURIAL, CREMATION, OR REMOVAL

PLACE Ozark DATE 11-29 M.D.

19. UNDERTAKER (ADDRESS)

Raymond J. Elliott20. FILED Nov. 29 1940 Wm. S. White Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-28 194022. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Oct 1, 1940I last saw him alive on Oct 1st, 1940 Death is saidto have occurred on the date stated above, at 29 m.

The principal cause of death and related causes of importance were as follows:

Heart Attack! Date of onset

Other contributory causes of importance:

Senile Dementia 6 Mo

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Dr. J. M. Reeds M. D.(Address) Summersville Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 5,

District File Number 12501199

Date Filed _____

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 44124

Registration District No. 1043

Primary Registration District No. 6141

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Osark 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 _____
years, months or days)

3. (a) PRINT FULL NAME Mary Belle 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 _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 1 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) _____ (b) _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 11 day 28 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 Heart attack
Due to Chronic Endocarditis
Due to _____

Other conditions Senile Dementia
(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) _____ (e) Means of injury _____

23. Signature J. M. Reads (M. D. or other) _____
Address Sumnerville Date signed _____

SUPPLEMENTAL

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

