

No. 2
4-13-40
5-17-39
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FILED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19207

Registration District No. 839 Primary Registration District No. 6101 Registrar's No. _____

1. PLACE OF DEATH:

(a) County: Stoddard

(b) City or town: Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Stoddard

(c) City or town: Rural (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.

3. (a) PRINT FULL NAME: Gerald West

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day May year 1941 hour 3 minute 10:0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: 0

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: 3 (Month) 14 (Day) 1941 (Year)

that I last saw h_____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE:

| Years | Months | Days | If less than one day |
|----------|----------|------|----------------------|
| <u>2</u> | <u>7</u> | | hr. _____ min. |

Pneumonia ✓

Due to _____

Due to _____

9. Birthplace: Stoddard County Mo. (City, town, or county) (State or foreign country)

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

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name: Cecily West

{ 13. Birthplace: Arkansas (City, town, or county) (State or foreign country)

{ 14. Maiden name: Elizabeth West

{ 15. Birthplace: Huntsville Alabama (City, town, or county) (State or foreign country)

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? 754 (Specify type of place)

16. (a) Informant: Elizabeth West

(b) Address: Wadley, Mo. Route 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-22-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Stoddard Co

18. (a) Signature of funeral director: [Signature]

(b) Address: Stoddard, Mo.

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

While at work? _____ (e) Means of injury: 3

23. Signature: [Signature]

Address: Blountfield, Mo. Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

3000

RA

109

RECEIVED

District Health Officer No. 2,

District File Number 641-265

Date Filed 6/9/41

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.

Body Not Embalmed

Signed

H. J. Welsh

Licensed Embalmer No. 774

P. O. Address Sikeston, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19207

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Richland
(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

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gerald West

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month May day 21
year 1947 hour _____ minute _____ M.

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

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 Pneumonia bronchial ✓

8. AGE: Years Months Days If less than one day _____ min.

2 7 _____

Due to _____

Due to _____

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

Other conditions NONE 107
(Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business _____

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____ (M. D. or other)

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

SUPPLEMENTARY

19207

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