FILED AUG 16 1941

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

24304
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 399 — Registration District No. 1002

(b) Township ..... — Primary Registration District No. ..... — Registered No. 2843

(c) City Kansas City — (d) Street No. Wesley Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. — (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. PRINT FULL NAME Mrs. Josie West

(a) Residence, No. 5829 East 16th. St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam M. West (71)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March, 27, 1876

7. AGE: YEARS 65 — MONTHS 3 — DAYS 29 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as saw mill, bank, etc. At Home
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jasper Co. Iowa

FATHER
13. NAME John Long
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

MOTHER
15. MAIDEN NAME Jane Spriggs
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT Sam N. West
(ADDRESS) 5829 East 16th.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Memorial Parkk DATE 7/28/41, 19..

19. FUNERAL DIRECTOR (NAME) Mrs. C. L. Forster
(ADDRESS) 918 Brooklyn

20. FILED 7-28, 1941 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 26, 1941

22. I HEREBY CERTIFY, That I attended deceased from July 21, 1941, to July 26, 1941. I last saw her alive on July 26, 1941. Death is said to have occurred on the date stated above, at 8:15 A.m.

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

myocarditis. Chr — Date of onset

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Other contributory causes of importance:
Cholecystectomy + appendectomy
Gallstones + Chr appendicitis

Name of operation Cholecystitis Date of July 22.
What test confirmed diagnosis? X Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no, 19 no
Where did injury occur? no
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. no
Manner of injury no
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify no
(Signed) J. F. Mackey, M. D.
(Address) Kansas City Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

SUM-T-12-38 I X14028

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 Gerald F. Wade

Licensed Embalmer No. 4172

P. O. Address 15 C. Rd.

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.