No. 2
4-41
-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 26 1942

Registration District No. 340371

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5546 4230

State File No. 2427

Registrar's No. 3

1. PLACE OF DEATH:

(a) County: Iron
(b) City or town: Ironton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days): two days
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Francois 96
(c) City or town: Bismarck (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Otto West
3. (b) If veteran, name war: no
3. (c) Social Security No. 493-01-2486
4. Sex: 0 male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Mattie L. West
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June (Month) 30 (Day) 1890 (Year)

8. AGE: Years	Months	Days	If less than one day
51	6	10	hr. min.

9. Birthplace: Doe Run (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation: merchant
11. Industry or business: Farm Co op store

FATHER
12. Name: Ollie West
13. Birthplace: Youngstown Ohio (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name: Fannie Beaver
15. Birthplace: Mo. (City, town, or county) (State or foreign country) 0

16. (a) Informant: Mrs. Otto West
(b) Address: Bismarck Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 1-12-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Bismarck Mo.
18. (a) Signature of funeral director: Norman White & Sons
(b) Address: Ironton Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10th year 1942 hour 11:00 P.M. minute 10 M.
21. I hereby certify that I attended the deceased from Jan. 9th 1942 to Jan. 10th 1942 that I last saw him alive on Jan. 10th 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: acute Bilateral Bronchio-Pneumonia	Jan. 10th 1942.
Due to: Relapse of Influenza	Dec. 10th 1941.
Due to:	
Other conditions (Include pregnancy within 3 months of death): Diabetes mellitus	??

Major findings:
Of operations: —
Of autopsy: none — 0

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: R. E. Harland M.D. (M. D. or other)
Address: Ironton, Mo. Date signed 1/13/42

1283 (Licensed Embalmer's Statement on Reverse Side)

FEB 1 3 19

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

Lyle N. White, Registered Apprentice No. 277

working under my personal supervision.

Signed Lyle N. White

Licensed Embalmer No. 3012

P. O. Address Lawton Okla.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2427

Registration District No. 391 Primary Registration District No. 4230 Registrar's No.

1. PLACE OF DEATH:

(a) County: Iron

(b) City or town: Ironton
(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 years, months or days)
In this community

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: Otto 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 years

7. Birth date of deceased: June (Month) 30 (Day) 1890 (Year)

8. AGE: Years 51 Months 6 Days 10 If less than one day hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1-14-42 (Date received local registrar) (b) Virginia R. Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 10 year 1942 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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)

(b) 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

SUPPLEMENTARY