

No. 2
484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3195

State File No. _____

FILED FEB 20 1942

Registration District No. 677676

Primary Registration District No. 5899

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rural Arlington Township
(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 Mo. (b) County phelps

(c) City or town Rural
(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 Isabell C. West

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mark West 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10 9 1848
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Isach Perkins

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

14. Maiden name Lizzie Lewis

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

16. (a) Informant Boy West

(b) Address Arlington, Mo.

17. (a) Burial (b) Date thereof 1/24/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kenner Cemetery

18. (a) Signature of funeral director Fred H. Gilbert
Dixon, Mo.

(b) Address _____

19. (a) 1-24-42 (b) Kelly Walker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 23
year 1942 hour _____ minute 4 A. M.

21. I hereby certify that I attended the deceased from 1-12-42 to 1-23-42 1942
that I last saw her alive on 1-12-42 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Hip joint & Age.

Due to _____

Due to _____

Other conditions _____
(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? Person Phelps Mo.
(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 Dr. C. C. Dixon (M. D. or other) _____
Address Dixon Date signed 1/24/42

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.....

Licensed Embalmer No.....

P. O. Address.....

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. **3195**
Registrar's No.

Registration District No. **676**

Primary Registration District No. **5899**

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

1. PLACE OF DEATH

(a) County **Phelps**
(b) City or town **Rural**
(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 **Isabell C. 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 **W**

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

7. Birth date of deceased **Oct 9**
(Month) (Day) (Year)

8. AGE: Years **93** Months **3** Days _____
(if less than one day) _____ min.

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

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 _____
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** Day **23**
year **1942** hour _____ minute _____ M.

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

Duration _____

Fracture hip
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) **Accident**

(b) Date of occurrence **Jan 13 - 42**

(c) Where did injury occur? **Washington Phelps, Mo**
(City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? **yes** (Specify type of place) (c) Means of injury **fall**

23. Signature **A. J. Brier** (M. D. or other) _____

Address **Nixon, Mo** Date signed _____

SUPPLEMENTARY

