FILED MAR 16 1942

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

7578
Do not use this space.

1. PLACE OF DEATH
(a) County Ralls. Registration District No. 727
(b) Township Saltriver. Primary Registration District No. 5959. Registered No. 12
(c) City (d) Street No. Perry, Missouri R.F.D. 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 Daniel W. West.
(a) Residence, No. Perry, Missouri R.F.D. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April, 7, 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	73	10	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer.
9. Industry or business in which work was done, as saw mill, bank, etc. Farm
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) Greenwood Co. Kansas.

FATHER
13. NAME Green M. West.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Virginia.

MOTHER
15. MAIDEN NAME Ester Hoover.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Indiana.

17. INFORMANT (ADDRESS) Mrs Alta Maddux. Perry, Missouri.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenlawn DATE March, 2, 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Clyde Wilkey Perry, Missouri.

20. FILED 2/28 1942 Mrs. Earl Perkinson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 28, 1942

22. I HEREBY CERTIFY, That I attended deceased from 2-22, 1942, to Feb 28, 1942
I last saw him alive on 2-27-, 1942. Death is said to have occurred on the date stated above, at 7:30 AM.
The principal cause of death and related causes of importance were as follows:

Bright disease (Parenchimatous Nephritis) — Date of onset

Other contributory causes of importance:

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) M. A. Suter, M. D.
(Address) Perry, Missouri.

(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.

50M-1-1-43 I X14023

RECEIVED
District Health Officer No. 10
District File Number 10-42-417
Date Filed MAR 11 1942

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, ...
Clyde Wilkey, or by .....,
Registered Apprentice No. ....., working under my personal supervision.

Signed Clyde Wilkey

Licensed Embalmer No. 3820

P. O. Address Perryton

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.

. S. No. 2B
10M—8-21-41
I 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. 7578

Registration District No. 725 Primary Registration District No. 5959 Registrar's No.

1. PLACE OF DEATH:
(a) County Ralls
(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 Daniel W. 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 w
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr (Month) 7 (Day) 1868 (Year)

8. AGE: Years 73 Months 10 Days 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Nephritis	
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)
(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 Suter (M. D. or other)
Address Date signed

SUPPLEMENTARY
131b