

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27974

State File No. _____

Registration District No. **292**

Primary Registration District No. **4435**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Ralls**
(b) City or town **Perry, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Perry, Missouri.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: **73 Yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lucy D. Westfall.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed.**
6. (b) Name of husband or wife **Frank Westfall** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May, 22, 1869**
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **22** If less than one day hr. min.

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

10. Usual occupation **Housewife.**

11. Industry or business **Home.**

12. Name **Peter A. Salling.**
13. Birthplace **Unknown Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret L. Dunn.**
15. Birthplace **Warsaw, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Clara Moore**
(b) Address **Vandalia, Missouri.**

17. (a) **Burial** (b) Date thereof **Sept. 2, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lick Creek Cemetery.**

18. (a) Signature of funeral director **Olyde Wiley**
(b) Address **Perry, Missouri.**

19. (a) **Sept. 2, 1942** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ralls**
(c) City or town **Perry, Missouri.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **Yes** No. _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **31**
year **1942** hour **10:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **Feb 23** 19**42** to **Aug 31** 19**42**
that I last saw her alive on **Aug 31** 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Duration **2 weeks**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **g3d**

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) (c) Means of injury _____

23. Signature **J. H. Brown** (M. D. _____)
Address **Perry** Date signed **9-3-42**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-42-1675-

Date Filed SEP - 8 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, Olydie W. Wilkey,

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3826

P. O. Address Perry, Pa.

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. 27974

Registration District No. 292 Primary Registration District No. 4435 Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Polk
(b) City or town Reynolds
(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)

3. (a) PRINT FULL NAME

Lucy O Westfall

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 widowed

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

7. Birth date of deceased May 22 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1942 hour _____ minute _____ M.

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

- Due to _____

- Due to _____

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

- 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.

