

No. 2
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5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 27 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10-279

State File No.

Registrar's No. **224**

Registration District No.

Primary Registration District No. **2000**

39
2
6

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

1. PLACE OF DEATH:
GREENE
 (a) County.....
 (b) City or town **SPRINGFIELD**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1947 Travis
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community **2 year** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Greene**
 (c) City or town **Springfield**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1947 Travis Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country..... **0**

3. (a) PRINT FULL NAME **JACK M. WEST**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **12**
 year **1943** hour **5** minute **30 P.M.**

4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **SARAH R WEST**
 6. (c) Age of husband or wife if alive **64** years
 7. Birth date of deceased **8 of 28 1873**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 1942** to **Mar 12 1943**
 that I last saw him alive on **Mar 11 1943**
 and that death occurred on the date and hour stated above.

8. AGE:
 Years **69** Months **4** Days **14**
 If less than one day hr. min.

Immediate cause of death **Cardio-Renal-Vascular**
 Duration **1 yr**

9. Birthplace **Greene Co Mo**
 (City, town, or county) (State or foreign country)

Due to.....
 Due to.....
 Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Farmer**

Major findings: **13/2**
 Of operations.....

11. Industry or business **Farming**

Of autopsy.....

MOTHER FATHER
 12. Name **Jerry West**

Physician **MO.**
 Underline the cause to which death should be charged statistically.

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

14. Maiden name **Unknown**

15. Birthplace **Unknown UNKNOWN**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Sarah J West**

(b) Address **1947 Travis Ave**

17. (a) **Burial** (b) Date thereof **3 14-43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Pisgah**

18. (a) Signature of funeral director **J. W. Kishner et al**

(b) Address **Springfield Mo**

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) Means of injury.....

23. Signature **May J. [unclear]** (M. D. or other) **MO.**
 Address **Springfield Mo** Date signed **3-13-43**

984 (Licensed Embalmer's Statement on Reverse Side)

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.....

Roy A. Gavin

Licensed Embalmer No. *1763*

P. O. Address.....

Springfield Mo

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.

[Handwritten mark]