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S. No. 2
M-9-4-41
V. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12963

State File No.

Registrar's No.

FILED APR 19 1943 318

Registration District No.

1003

3318

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Missouri**
(c) Name of hospital or institution:
St. Louis City Hospital
(d) Length of stay: In hospital or institution..... **10 Days**
In this community..... **50 yrs.**

3. (a) PRINT FULL NAME **Berry West**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Annie** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **January 3, 1868**

8. AGE: Years Months Days If less than one day
75 3 3 hr. min.

9. Birthplace **Lebanon Missouri**

10. Usual occupation **Wood worker**

11. Industry or business.....

12. Name **Thomas West**

13. Birthplace **not known**

14. Maiden name **not known**

15. Birthplace **not known**

16. (a) Informant **Max West**

(b) Address **5202 Louisiana**

17. (a) **Burial** (b) Date thereof **4-8-43**

(c) Place: burial or cremation **Sunset Burial**

18. (a) Signature of funeral director **John R. Ziegenhein**

(b) Address **7027 Gravois Ave.**

19. (a) **APR 8 1943** (b) **J. F. Brudack**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(d) Street No. **Ozanam Shelter**
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **6**, year **1943** hour **11:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **March 28, 1943** to **April 6, 1943** that I last saw him alive on **April 6, 1943** and that death occurred on the day and hour stated above.

Immediate cause of death **Pulmonary tuberculosis - bilateral far advanced**

Due to.....
Due to.....
Other conditions.....
Major findings:
Of operations.....
Of autopsy **Not allowed**

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

23. Signature **Wm. R. Leary** M. D. or other
Address **1515 Lafayette Avenue** Date signed **4/7/43**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

E. P. Kidwell
3877
7027 Gravois

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.