

7. S. No. 2
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Rev. 5-17-39
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14739

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED MAY 8 1943
Registration District No. 178

Primary Registration District No. 4285

Registrar's No. 43

1. PLACE OF DEATH:
(a) County LEWIS
(b) City or town LEWISTOWN
(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 years, months or days) 90 yrs; 5 mos; 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County LEWIS
(c) City or town LEWISTOWN
(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 JOSEPH ANDERSON WEST
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 5th year 1943 hour 11 PM minute _____ M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, widowed 2 divorced, widowed
6. (b) Name of husband or wife MARY NANCY WEST 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 4, 1852 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 1, 1943 to April 5, 1943 that I last saw him alive on April 5, 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 5 Days 1 If less than one day _____ hr. _____ min.

Immediate cause of death: Meningo Toxicosis. Duration 8 days
Due to Prostate 2 yrs

9. Birthplace MONTICELLO MO 0 (City, town, or county) (State or foreign country)
10. Usual occupation RETIRED MERCHANT

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 137a

11. Industry or business
12. Name RICHARD WEST
13. Birthplace Unknown, Ohio 1 (City, town, or county) (State or foreign country)
14. Maiden name MARY ANDERSON
15. Birthplace Unknown Ohio 1 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Laure West
(b) Address Monticello MO
17. (a) Burial (Barial, cremation, or removal) (b) Date thereof 4/17/43 (Month) (Day) (Year)
(c) Place: burial or cremation MONTICELLO, MO
18. (a) Signature of funeral director Laure A. Cadon
(b) Address Leuters town MO
19. (a) 4/17/43 (Date received local registrar) (b) P. W. Jennings, MD (Registrar's signature)

23. Signature: P. Hillard (M: D. or other) P.D.
Address: Canton MO Date signed 4/24/43

(Licensed Embalmer's Statement on Reverse Side)

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

56

50

56

0

0

(Yes or No)

1

Duration

8 days

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.