

S. No. 2
OM-5-42
7-5-17-37
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3649

State File No. _____
Registrar's No. **9595**

FILED NOV. 10 1943

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Josephine Heitkamp
(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 William H. 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 Jennie West

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

7. Birth date of deceased Sept 27 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>78</u>	<u>1</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace St. Paul Minn.
(City, town, or county) (State or foreign country)

10. Usual occupation CLERK

11. Industry or business BRASS foundry

12. Name Judson West

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

14. Maiden name Helen Sweet

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

16. (a) Informant Mrs Jennie West

(b) Address Edwardsville, Ill

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 1943
(Month) (Day) (Year)

(c) Place: burial or cremation MT Lebanon Cem - St. Louis

18. (a) Signature of funeral director Frank

(b) Address Edwardsville Ill

19. (a) NOV 1 1943 (Date received local register) (b) J. J. Bredask (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County MADISON

(c) City or town EDWARDSVILLE
(If outside city or town limits, write "RURAL")

(d) Street No. 744 Holly Dr
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30
year 1943 hour 6 minute 50 P. M.

21. I hereby certify that I attended the deceased from Oct 17 to Oct 30, 1943
that I last saw him alive on Oct 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Lobar 5 days
Myocarditis Chronic 3 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

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? _____

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature Philip Seluck (M. D. or other)

Address 1703 S. Grand Date signed 10/30/43

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

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:

Frank Prokoff

Licensed Embalmer No.

4356

P. O. Address

St. Louis 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.