

FILED OCT 13 1944

State File No. _____

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

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

(d) Street No. 314. S. Whitmer St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Zeffie Lee West

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joe West

6. (c) Age of husband or wife if alive 1889 years

7. Birth date of deceased Oct. 2. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 11 15 hr. min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name J. D. Hill

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

14. Maiden name Annie Dunbar

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

16. (a) Informant Joe West

(b) Address Richmond. Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept. 21. 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Richmond. Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Richmond. Mo.

19. (a) 9-21-44 (Date received local registrar)

(b) Mrs. Hae W. Shippard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1944 hour 7 minute 20.A. M.

21. I hereby certify that I attended the deceased from 9-1-44 to 9-17-44, 19____; that I last saw her alive on 9-17-44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) H&R

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 [Signature] (M. D. or other) MD

Address Richmond, Mo. Date signed 9-22-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1240

RECEIVED

RECEIVED

District Health Officer No. 8,
District Health Officer No. 8,

District File Number

Date Filed

10-11-44

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, ###
....., Registered Apprentice No.
working under my personal supervision.

Signed *E. J. ...*
.....
Licensed Embalmer No. 2073
.....
P. O. Address Richmond, 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.