

FILED FEB 14 1945
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2510 Perry Peery
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 22 years
(Specify whether years, months or days)

3. (a) PRINT FULLNAME John West
(b) If veteran, name war no
(c) Social Security No. 495-09-475

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Blanche West
(c) Age of husband or wife if alive about 35 years

7. Birth date of deceased January 30 1893
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 29
If less than one day hr. min.

9. Birthplace Egypt Miss. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business K.C. Quartermaster Depot

12. Name Primes West

13. Birthplace Corrent Miss. 1
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta Payne Va. 1
(City, town, or county) (State or foreign country)

15. Birthplace _____

16. (a) Informant A. C. West

(b) Address 4402 Vincennes, Chicago, Ill

17. (a) Removal (b) Date thereof 2-1-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director E. Stealing Bell

(b) Address 1212 Vine St., K.C. Mo.

19. (a) 2-1-45 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2510 Perry Peery
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 29
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him/her alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death United Dilatation of Heart
Due to _____

Due to _____
Other conditions 956
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy Dup - History
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)
(e) Means of injury _____
23. Signature J. F. Richardson (M., D., or other) _____
Address 9832 Jane Date signed 1-31-45

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

E. Sterling Bells

Licensed Embalmer No. *3178*

P. O. Address *1217 Pine K. (C)*

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.