

U.S. No. 2
DM-5-43
V. 5-17-39
I X36571

FILED SEP 10 1945
Registration District No. 147

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: General Hospital ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether)

In this community 63 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2739 Myrtle 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Martha West

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex R 5. Color or race Wh

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

6. (b) Name of husband or wife Thos H West

6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased Sept 10 - 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25
year 1945 hour 7 minute 46 P. M.

21. I hereby certify that I attended the deceased from August 18 1945 to August 25 1945
that I last saw h. er. alive on August 25 1945
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral vascular accident

Duration _____

8. AGE: Years 73 Months 11 Days 15
If less than one day hr. min.

Due to _____

Due to _____

9. Birthplace Devonshire England
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

Major findings: 83a
Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name John Blakke

22. If death was due to external causes, fill in the following:

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

(a) Accident, suicide, or homicide (specify) _____

14. Maiden name Charlotte Ogler

(b) Date of occurrence _____

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

(c) Where did injury occur? _____ (City or town) (County) (State)

16. (a) Informant Thos H West

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

(b) Address 2739 Myrtle, K.C. Mo.

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-28-45
(Month) (Day) (Year)

(c) Place: burial or cremation St Marys

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

18. (a) Signature of funeral director Melroy Mcgilly

23. Signature Clark W Selby MD (Physician's signature) (b) Address Med. Dir. K.C. General Hospital

(b) Address Ogler - K.C. Mo.

19. (a) 8-27-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

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. *2999*

P. O. Address..... *KC*

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.