

FILED SEP 25 1945

Registration District No. **2000**

Primary Registration District No. **2000**

Registrar's No. **730**

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

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 2124 W. National 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 yrs. (Specify whether years, months or days)
 In this community 3 yrs.

3. (a) PRINT FULL NAME JOHN ANDREW WEST
 3. (b) If veteran, name war No
 3. (c) Social Security No. No.

4. Sex Male 5. Color of hair White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife W.A.K.
 6. (c) Age of husband or wife if alive Dec. 15, 1870 years (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 28
 If less than one day hr. min.

9. Birthplace Golden Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired mail carrier

11. Industry or business Retired

12. Name John C. West

13. Birthplace Deersfield Ill. 1
(City, town, or county) (State or foreign country)

14. Maiden name Sarah E. Strattan

15. Birthplace Clayton Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Allen

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof Sep 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Golden Ill.

18. (a) Signature of funeral director W. Klingner Co.

(b) Address Springfield, Mo.

19. (a) 9-14-45 (b) W. H. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Greene 39
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 2124 W. National 6
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
 year 1945 hour 4 minute 55 P. M.

21. I hereby certify that I attended the deceased from Sept 12 1945 to Sept 13 1945
 that I last saw him alive on 9-12 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death acute heart
failure Duration

Due to Indigestion

Due to Indigestion

Other conditions 18.3
(Include pregnancy within 3 months of death)

Major findings: none

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? Springfield, Mo.
(City or town) (County) (State)

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

While at work? Indigestion (Specify type of place) (e) Means of injury ○

23. Signature A. J. Trumia (M. D. or other)

Address Springfield, Mo. Date signed 9-4-5

984

14 - 4

SFP 25 1947

NOV 28 1945

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

J. B. Klingner

Licensed Embalmer No. 3358

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.