S. No. 2
M—8-43
. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31275

Registration District No. 292 Primary Registration District No. 4434 Registrar's No.

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Center (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 years, months or days)
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls 87
(c) City or town Center, Mo. 0 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas P. West
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Julia Shulse West
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 31 1860 (Month) (Day) (Year)
8. AGE: Years 84 Months 7 Days 26 If less than one day hr. min.
9. Birthplace Monroe Co Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation Framer
11. Industry or business Retired
FATHER 12. Name Jackson West
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)
MOTHER 14. Maiden name Kizzie -----West
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Mrs. H. D. Shulse
(b) Address Center Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 45 (Month) (Day) (Year)
(c) Place: burial or cremation Center Cemetery
18. (a) Signature of funeral director [signature]
(b) Address Center, Mo
19. (a) Sept 1-1945 (Date received local registrar) (b) Mrs Earl Perkinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1945 hour 6 minute 15a M.
21. I hereby certify that I attended the deceased from Aug 3 1945 to Aug 27 1945; that I last saw him alive on Aug 27 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of neck - Stomach and intestinal tract	3 mo.
Due to unknown	
Other conditions Unknown (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

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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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. H. Brooks (M. D. or other) D.O.
Address Center, Mo Date signed Aug. 31 1945

1135

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1434
Date Filed SEP-1-7-1945

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 Gilbert Strube

Licensed Embalmer No. 4263

P. O. Address Center 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.