No. 2
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X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 29 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14447

Registration District No. 317 Primary Registration District No. 4467 Registrar's No. 868

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Near Valley Park, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Dudley's Tourist Camp 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Abuut 12 hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana (b) County Hendricks 99
(c) City or town Rural 12
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Fern Hazel West

3. (b) If veteran, name war ----- 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leland P. West 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Oct. (Month) 28 (Day) 1897 (Year)

8. AGE: Years 48 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Carrol Co. (City, town, or county) Indiana (State or foreign country)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name John Gray
13. Birthplace Cleveland Co. (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Clara Corbin
15. Birthplace Rush Co. (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Leland P. West
(b) Address Near Coates ville Indiana

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4 (Month) 15 (Day) '46 (Year)
(c) Place: burial or cremation Coatesville Indiana

18. (a) Signature of funeral director MITTELBERG FUNERAL HOME, Inc.
(b) Address WEBSTER GROVES, MO.

19. (a) 4-18-46 (Date received local registrar) (b) E. G. McGarrah M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 15
year 1946 hour 6 minute 30 p M.

21. I hereby certify that I attended the deceased from Death without medical attendance, to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary tuberculosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No autopsy	

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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 0

23. Signature E. G. McGarrah M.D. (M. D. or other)
Address 601 Brentwood Blvd. Date signed 4/15/46

(Licensed Embalmer's Statement on Reverse Side)

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 Henry M Brammer

Licensed Embalmer No. 4700

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.