

No. 2  
-5-43  
-17-39  
X36671

FILED JUN 7 1946 STANDARD CERTIFICATE OF DEATH

State File No. 16062

Registration District No. 41

Primary Registration District No. 3012

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 days  
(Specify whether  
In this community 28 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Oronogo  
(If outside city or town limits, write "RURAL")  
(d) Street No. -  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Daniel D. West  
3. (b) If veteran, name war World War I  
3. (c) Social Security No. 500-01-9986

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife Single  
6. (c) Age of husband or wife if alive 26 years (Month) (Day) (Year)  
7. Birth date of deceased May 26 1890

8. AGE: Years 55 Months 11 Days 14  
If less than one day hr. min.

9. Birthplace Joplin Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Miner

11. Industry or business Mines

12. Name S. P. West

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

14. Maiden name Ellen Howard

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

16. (a) Informant Hospital Records, Veterans Admin

(b) Address istration, Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 5-10-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Webb City, Mo.

18. (a) Signature of funeral director Webb City Undertaking Co.

(b) Address Webb City, Mo.

19. (a) 5/11/46 (b) Caroline Hutchings  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th  
year 1946 hour 9:55 minute A. M.

21. I hereby certify that I attended the deceased from April 13 1946 to May 10 1946  
that I last saw h. im. alive on May 10 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active 4  
Duration Unknown

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 12K

Of autopsy No autopsy performed

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) (e) Means of injury OO

23. Signature Ernest M. Tapp (M. D. or other) M. D.

Address Veterans Administration Hospital 5-10-46

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-5-46

JUN 10 1946

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 Clayton Johnston  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address Webb City, 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.