

FILED AUG 9 1946 STANDARD CERTIFICATE OF DEATH

23162

State File No. _____

Registration District No. 98

Primary Registration District No. 4160

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Daviess
(b) City or town Winston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Sarah Katherine West

3. (b) If veteran, name war _____ # _____ 3. (c) Social Security No. # _____

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles West 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased July 1 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 9 If less than one day
hr. min.

9. Birthplace Daviesss County (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Charles E Stecker
13. Birthplace Penn (State or foreign country)
14. Maiden name Martina M. Castor (State or foreign country)
15. Birthplace Da viess Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Charles E. West
(b) Address Winston .Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 1946
(Month) (Day) (Year)
(c) Place: burial or cremation Winston Mo

18. (a) Signature of funeral director The Natl. Stecker
(b) Address Winston Mo
19. (a) July 22 46 (Date received local registrar) (b) Triguard Englehart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1946 hour 5. minute 05 P. M.

21. I hereby certify that I attended the deceased from Nov 1945 to July 10th 46;
that I last saw her alive on July 10th 46;
and that death occurred on the date and hour stated above.

Immediate cause of death Carabral hemorrhage

Due to Hypertension.

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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 _____

23. Signature Fred Wilson (M. D. or other) _____
Address Winston Mo Date signed July 11, 46

Duration
8 mo

several
yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

AUG 13 1948

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 *L. O. Pichman*
Licensed Embalmer No. *3307*
P. O. Address *Fallatio, 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.