

FILED AUG 27 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 935

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: State Hosp # 2
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 yrs 6 mo 3 da
In this community 4 yrs. 6mo. 3 da. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 3714 Central
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Cleo 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 Harold West 6. (c) Age of husband or wife if alive not stated years

7. Birth date of deceased not given
(Month) (Day) (Year)

8. AGE: Years about 42 Months ? Days ? If less than one day hr. min.

9. Birthplace Creston Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name not given

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

14. Maiden name Josephine Gentry

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

16. (a) Informant Harold West

(b) Address 719 W 45th Mo.

17. (a) Removal (b) Date thereof 8-15-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Walter Neishoff

(b) Address St. Joseph, Missouri

19. (a) Aug. 21, 1946 (b) St. Joseph, Mo.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1946 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from Aug 1
1946, 1946, to Aug 15, 1946;
that I last saw her alive on Aug 14, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy (36 hrs. continuous)
Syphilis
Duration 4 yrs

Due to _____

Due to _____

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

Major findings: _____

Of operations 300g

Of autopsy _____

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?

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

23. Signature L. J. Thiel (M. D. or other) M.D.
Address State Hosp. #2 Date signed 8/15/46

JAN 24 1955

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 *Albert C. Harrington*
Licensed Embalmer No. *3258 No*
P. O. Address *St. Joseph, 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.