S. No. 2
M—8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26881

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 699

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2
6

25724

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Born in - 4 Da (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County TANCY 106

(c) City or town Forsyth (Parents' home) 0
(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) 1

If yes, name country

3. (a) PRINT FULL NAME West, Annie Lee

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased August (Month) 20 (Day) 1946 (Year)

8. AGE: Years 0 Months 0 Days 4 days If less than one day hr. min.

9. Birthplace Springfield (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Ralph West
13. Birthplace UNK. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Ida Mae Langbary
15. Birthplace UNK. (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant Ralph West
(b) Address Forsyth - Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-46 (Month) (Day) (Year)
(c) Place: burial or cremation Forsyth - Mo.

18. (a) Signature of funeral director Family Disposal
(b) Address By Mr. West Forsyth - Mo.

19. (a) 8-25-46 (Date received local registrar) (b) Dr. W. J. Hardley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24 year 1946 hour 11 minute 16 a. M.

21. I hereby certify that I attended the deceased from 20 Aug, 1946, to 24 Aug, 1946; that I last saw her alive on 24 Aug, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Underdevelopment of Respiratory Center	
Due to Prematurity	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

157D

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? Body removed (Specify type of place)

While at work? (e) Means of injury 0

23. Signature R. Medwhite (M. D. or other) MD

Address Woodruff Bldg Springfield Mo. Date signed 24 Aug 46

111

(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.

This body was not Embalmed.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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. X