

**FILED** *091 38 1948*

Registration District No. \_\_\_\_\_

Primary Registration District No. *5099*

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Bates  
 (b) City or town Walnut Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
none  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Bates  
 (c) City or town Walnut twp.  
(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 Albert McCellan West  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month SEPT day 15<sup>TH</sup>  
 year 1946 hour 4 minute 30 P. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Dec. 25, 1866  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Carcinoma of face  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>8</u>	<u>20</u>	hr. _____ min. _____

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 53  
 Of autopsy no  
 Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name James West  
 13. Birthplace Ind.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Laird  
 15. Birthplace Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert West

(b) Address Foster Missouri

17. (a) Burial (b) Date thereof 9-18-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Benjamin cemetery

18. (a) Signature of funeral director Archer & Mangold

(b) Address Amsterdam Mo.

19. (a) Sept 21, 46 (b) Fern H. Martin  
(Date received local registrar) (Registrar's signature)

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 3

23. Signature John G. Underwood (M. D. or other) Coroner

Address 13 Butler Mo. Date signed 9-16-46

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

RECORDED  
District Health Officer No. 70  
District No. Number 9-46-1004  
Date Filed 10-7-46

---

**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, ~~XXXX~~.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed L. A. Mangold.....  
Licensed Embalmer No. 3610.....  
P. O. Address Amsterdam, 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.**