

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 20 1946**  
STANDARD CERTIFICATE OF DEATH

State File No. 33832  
Registrar's No. 4384

Registration District No. 199 Primary Registration District No. 1002

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

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days  
(Specify whether  
In this community 6 days  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County Jackson  
(c) City or town Lowry City, Mo.  
(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** Roberta Jean West  
3. (b) If veteran, name war no 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**  
20. **DATE OF DEATH:** Month Oct. day 17th.  
year 1946 hour 5.50 P.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 10/14/46, 19\_\_\_\_, to 10/17/46, 19\_\_\_\_;  
that I last saw him alive on 10/17/46, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single (Single, widowed, married, divorced, Child) Child  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept. 6, 1946  
(Month) (Day) (Year)

Immediate cause of death Congenital Pyloric obstruction  
Due to atelectasis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 161a  
Of operations \_\_\_\_\_  
Of autopsy See above

8. **AGE:** Years Months Days If less than one day  
1 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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?  
Physician \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Clinton, Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation infant  
11. Industry or business \_\_\_\_\_

**MOTHER** { 12. Name Robert E. West  
13. Birthplace Prairie Grove, Ark.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mabel Cook  
15. Birthplace Callao, Mo.  
(City, town, or county) (State or foreign country)

**FATHER** { 16. (a) Informant Robert E. West  
(b) Address Lowry City, Mo.  
17. (a) Removal (auto) (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1946  
(Month) (Day) (Year)  
(c) Place: burial or cremation Prairie Grove, Ark.

18. (a) Signature of funeral director Thomas E. Quirk Funeral Home  
(b) Address 4316 Troost Ave.  
19. (a) 10-18-46 (Date received local registrar) (b) Sheldine Holmes (Registrar's signature)

23. Signature OT 17th (M. D. or other) \_\_\_\_\_  
Address 1109 Prof Bldg/Kans Date signed 10/18/46

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**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..... *Thomas E. Jewell*  
.....  
Licensed Embalmer No..... *3775*  
..... *N. E. Mo*  
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.**