

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Independence Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
In this community 17 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri Jackson 48  
(a) State (b) County  
(c) City or town Intercity District Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 213 South Hardy  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

ALLEN JOSEPH WEST

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 5th 1946  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation (Infant)

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

12. Name William H. West 9

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

14. Maiden name Lillian Margaret Rivers

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

16. (a) Informant Mr. George Jensen

(b) Address 213 S. Hardy, Intercity Dist.

17. (a) Burial (b) Date thereof Oct. 26, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Geo. C. Carson

(b) Address Independence, Missouri

19. (a) 10-26-46 (b) Jan. Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24th  
year 1946 hour 3 minute 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.

Immediate cause of death Dehydration Acidosis Malnutrition Cause unknown  
Duration 2 wks  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy, within 5 months of death)

Major findings: 66 Pa  
Of operations \_\_\_\_\_

Of autopsy See Above

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) (c) Means of injury \_\_\_\_\_

23. Signature A. E. Upsher (M. D. or other) MD  
Address 2800 Main Date signed 10/25/46

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

MOTHER FATHER

**.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.....

*R. A. Lisle*

Licensed Embalmer No.....

*4123*

P. O. Address.....

*Independence, 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.**