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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8849

State File No.

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 43

1. PLACE OF DEATH:

(a) County HOWELL

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

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

(d) Length of stay: In hospital or institution No. (Specify whether In this community 55 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL

(c) City or town WEST PLAINS (If outside city or town limits, write "RURAL")

(d) Street No. 516 WALNUT (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CECIL MAY WEST

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife O. PERRY WEST

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased MAY (Month) 9, (Day) 1891 (Year)

8. AGE: Years 55 Months 9 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name DAVID PALMER
13. Birthplace McARTHUR Co., (City, town, or county) VA. (State or foreign country)

MOTHER
14. Maiden name ANGIE OGAN
15. Birthplace (City, town, or county) OHIO (State or foreign country)

16. (a) Informant O.P. WEST

(b) Address WEST PLAINS, Mo.

17. (a) OAK LAWN CEM. (Burial, ~~cremation, or removal~~) (b) Date thereof MAR. 9, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation WEST PLAINS, Mo.

18. (a) Signature of funeral director Hal Thornburgh

(b) Address WEST PLAINS, Mo.

19. (a) Mar 10-1947 (Date received local registrar) (b) Beatrice Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 4, year 1947 hour 3: minute 20 A.M.

21. I hereby certify that I attended the deceased from 1942 to 3-4-1947; that I last saw her alive on March 3, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	7 hrs.
Due to: General Arteriosclerosis	6 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. C. Bohrer (M. D. or other) MD

Address West Plains Mo Date signed 3-6-47

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District [illegible] No. 5
District File No. 347157
Date Filed 3-24-47

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 S. L. Duncan, Registered Apprentice No. 390, working under my personal supervision.

Signed Hal Thornbrough

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.