

No. 2
12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17673

State File No. 1115

Registrar's No. 2383

Registration District No. 149

Primary Registration District No. 1002

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: Research Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 4 Weeks (Specify whether
4 Weeks (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Sylas LeRoy West

3. (b) If veteran, name war World War 1 3. (c) Social Security No. Cant Find

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

6. (b) Name of husband or wife Cleo S. West 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased. 2 27 1897
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>3</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Druggist

11. Industry or business _____

12. Name Daniel B. West

13. Birthplace No Record
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Etta Morgan

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

16. (c) Informant Mrs. Cleo S. West

(b) Address Kirksville, Missouri

17. (a) Removal (b) Date thereof 5-29-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville, Missouri

18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address Kansas City, Missouri

19. (a) 5-30-47 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town Kirksville, Missouri
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no. (Yes of No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th
 year 1947 hour 1 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from Jan 12-1947
 _____, 19____, to May 29, 1947
 that I last saw him alive on May 28, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death
arterial Hypertension 2 yrs
Chronic Nephritis 6 mos.
Engorgement of nasal
nasillary sinuses 3 mos.

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

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 Graham Asher (M. D. or other) M.D.
 Address 11220 Ry. Bldg Date signed 5-29-47

Duration
2 yrs
6 mos.
3 mos.

PHYSICIAN

 Underline the cause to which death should be charged statistically.

JUL 22 1947

NOV 17 1947
NOV 17 1947

Dr. Graham Asher
Prof. R. Bldg.

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 A. Redman*

Licensed Embalmer No. *2737*

P. O. Address. *B.C. me*

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.