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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 233606

FILED OCT 29 1947

Registration District No. 70

Primary Registration District No. 3002

Registrar's No. 151

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

1. PLACE OF DEATH:

(a) County Andrew

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

(c) Name of hospital or institution:  
Mexico Mo General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ida May West

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William R West

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased: 6 (Month) 12 (Day) 1887 (Year)

8. AGE: Years 60 Months 4 Days 6 If less than one day hr. min.

9. Birthplace Wabash Co Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business General Duties

12. Name John Cunningham

13. Birthplace Wabash Co Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Sara Paul

15. Birthplace Wabash Co Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant William R. West

(b) Address Bellflower Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Bellflower Mo

18. (a) Signature of funeral director Wanda A Jones

(b) Address Bellflower Mo

19. (a) 10/18/47 (Date received local registrar) (b) Blanche Neely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery 70

(c) City or town Bellflower Mo  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 1947 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 17, 1947, to Oct 18, 1947;  
that I last saw her alive on Oct 18, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 30 min.

Due to Aorta regurgitation 10 years.

Due to \_\_\_\_\_

Other conditions Senility  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 92A

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 2

23. Signature K. D. Swan (M. D. or other) 10.0

Address 100 S. W. Jones St. Date signed 10-18-47

Mexico Mo

RECEIVED  
District Health Officer No. 10  
District File Number 10-47-477  
Date Filed OCT 28 1947

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 Aland A. Jones  
Licensed Embalmer No. 2973  
P. O. Address Bellflower 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.