

No. 2
-12-45
5-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33980**
Registrar's No. **165**

Registration District No. **77** Primary Registration District No. **3012**

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

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
312 Foley Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay **24**
(c) City or town Excelsior Springs /
(If outside city or town limits, write "RURAL")
(d) Street No. 312 Foley St., /
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CORBIN J. L. WEST
3. (b) If veteran, name war No
3. (c) Social Security No. 493-22-6952

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month OCT. 27 day 1947
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from NOV. 28
1946, to OCT. 27, 1947;
that I last saw him alive on OCT. 22, 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Singled
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased April 26 1918
(Month) (Day) (Year)

Immediate cause of death AURICULAR*VENTRICULAR Duration
BLOCK.
Due to CARDIO-RENAL FAILURE
GENERALIZED EDEMA
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
29 6 1 _____ hr. _____ min.

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Construction Laborer

11. Industry or business _____

12. Name Wm. Ernest West

13. Birthplace Clay County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Dora Beatrice Grimes

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

16. (a) Informant Jm. West

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof 10/29/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty, Missouri

18. (a) Signature of funeral director Claude Trichard

(b) Address Excelsior Springs, Mo.

19. (a) 10-29-47 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

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 _____
23. Signature Jm. West (M. D. or other) MD.
Address Excelsior Springs Mo. Date signed 10/28/47

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 11-13-47.....

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Albert E. White*.....

Licensed Embalmer No. 4168.....

P. O. Address. Excelsior Springs, 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.