S. No. 2
DM—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 6 1948

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43992

Registration District No. 381 Primary Registration District No. 4515 Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 66 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 105

(a) State Mo (b) County Sullivan
(c) City or town Milan 1
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Perry West
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex m d
5. Color or race w
6. (a) Single, widowed, married, divorced Married /
6. (b) Name of husband or wife Mattie M West
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Aug (Month) 28 (Day) 1882 (Year)

8. AGE: Years 65 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Milan (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation
11. Industry or business Laborer
FATHER
12. Name Jacob West
13. Birthplace (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Mary F McNeice
15. Birthplace (City, town, or county) (State or foreign country) 9
16. (a) Informant Mattie M West
(b) Address Milan - Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood - Milan
18. (a) Signature of funeral director Schoene
(b) Address Milan Mo
19. (a) Dec. 29-1947 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature) 420

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 1 year 1947 hour 12 minute 30 P M.

21. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ a few minutes after death, 19 , to , 19 ; that I last saw him alive on notre recorded, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death probably a coronary occlusion — Duration a few minutes

Due to ? Probable embolism

Due to

Other conditions chronic myocarditis.
(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 0

23. Signature J. S. Montgomery (M. D. ~~or other~~)
Address Milan Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

JAN 1 C 1948

RECEIVED
District Health Officer No. 10
District File Number 1:48:19
Date Filed JAN -5 1948

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 Dwight Schauer

Licensed Embalmer No. 2667

P. O. Address Nelson 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.