

FILED JAN 17 1948

Registration District No. 192

Primary Registration District No. 4308

Registrar's No. 36

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Noel
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 years years, months or days

3. (a) PRINT FULL NAME Eglen Edmore West

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased: Sept 7 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation: retired

11. Industry or business _____

12. Name Joseph West
13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name Jessie Rayson
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Elliott
(b) Address noel mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Noel

18. (a) Signature of funeral director W. A. Bryant
(b) Address Kezette Ark

19. (a) 1-8-48 (Date received local registrar) (b) Virginia Buck (Registrar's signature) 271

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County McDonald
(c) City or town Noel (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 3 hour _____ minute 0 M.

21. I hereby certify that I attended the deceased from June 1947 to Dec 17 1947
that I last saw him alive on Dec 17 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion Duration 1 hour

Due to: Chronic myocarditis 2 years

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? _____

While at work? _____ (Specify type of place) (a) Means of injury ?

23. Signature H. D. Fountain (M. D. or other) Dr
Address Noel mo Date signed Dec 17

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

6088

RECEIVED
District Health Officer No. 6,
District File Number 14884
Date Filed JAN 14 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 E. R. Pyeatt

Licensed Embalmer No. 3211

P. O. Address Granette Ark.

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, above space should be left blank.