

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED OCT 1 1948

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 30375

Registration District No. 207

Primary Registration District No. 5753

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Monroe
 (b) City or town Meta, Mo. (Rural)
 (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 ALL HIS LIFE. years, months or days

3. (a) PRINT FULL NAME JOHN JACKSON WEST

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

4. Sex MO 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife OLIVE WEST
 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased Nov. 7 1867
 (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 8
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name WARREN ABNER WEST

13. Birthplace KENTUCKY
 (City, town, or county) (State or foreign country)

14. Maiden name MARTHA THOMPSON

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

16. (a) Informant MRS. ULYSSES PENDLETON

(b) Address BELLE, MO.

17. (a) Burial (b) Date thereof 18 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meta Southside Cem.

18. (a) Signature of funeral director H. H. Shop

(b) Address Meta, Mo.

19. (a) 9-20-48 (b) Pauline Howard
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Monroe
 (c) City or town Meta, Mo. (Rural)
 (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16 year 1948 hour 12:10 minute P. M.

21. I hereby certify that I attended the deceased from FEB 19 1948 to Sept 16 1948
 that I last saw him alive on Sept 16 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death CANCER
 Duration 20 yrs.

Due to metastatic Cancer

Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REGISTERED

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 S. W. Gaston (M.D. or other) P.O.
 Address Meta, Mo. Date signed 12/16/48

RECEIVED
District Health Officer No. 9,
District File Number
SEP 30 1948
Date Filed

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 H. H. Shop
Licensed Embalmer No. 2924
P. O. Address Meta 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 100
Registrar's No. 30

Registration District No. 207

Primary Registration District No. 5753

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural
(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 years, months or days)

3. (a) PRINT
FULL NAME

3. (b) If veteran,
name war

3. (c) Social Security
No.

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 11
(If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1944 year 1944 hour 4 minute 15 M.

21. I hereby certify that I attended the deceased from to, 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Other conditions (Include pregnancy within 3 months of death)

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

S-30375