

Registration District No. **71**

Primary Registration District No. **3012**

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 **NEITHER**
(Specify whether)
In this community **LIFETIME**
years, months or days

3. (a) PRINT FULL NAME **WILLIAM ERNEST WEST**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **491-01-19608**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **DORA GRIMES WEST** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **MARCH 10 1892**
(Month) (Day) (Year)

8. AGE: Years **56** Months **8** Days **0** If less than one day
hr. min.

9. Birthplace **RAY COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **PAINTER - DECORATOR**

11. Industry or business **NONE**

12. Name **NEWTON WEST**

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

14. Maiden name **MARY JANE FIRZSDN**

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

16. (a) Informant **Mrs. Dora G. West**

(b) Address **312 Foley, Excelsior Springs, Mo.**

17. (a) **BURIAL** (b) Date thereof **NOV. 13 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LIBERTY, MO. CEMETERY**

18. (a) Signature of funeral director **Clairie Prichard**

(b) Address **Excelsior Springs, Mo.**

19. (a) **11/13/48** (b) **Caroline Duthing**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CLAY 24**
(c) City or town **EXCELSIOR SPRINGS 1**
(If outside city or town limits, write "RURAL")
(d) Street No. **312 FOLEY STREET 1**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **-**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **10**
year **1948** hour **4:45** minute **P.M.**

21. I hereby certify that I attended the deceased from **12/14/46**
to **11/10/48**
that I last saw him alive on **11/10/48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of stomach**
(- linitis plastica) involving
omentum and lymph glands unkn.

Due to _____
Due to _____

Other conditions **46B**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **Exploratory operation**
9/9/48 closed up, nothing removed
Of autopsy **None**

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 **W. M. Cruden** (M. D. or other) **MD**
Address **Excelsior Springs, Mo.** Date signed **11/14/48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

11-24-48

NOV 24 1948

DEC 8 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: *Lindee K. Jarman*

Licensed Embalmer No. 4589

P. O. Address: *Euclid Springs, T*

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.