

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4410**

BIRTH NO. _____		REG. DIST. NO. 98		PRIMARY REG. DIST. NO. 4165		Registrar's No. 20	
1. PLACE OF DEATH a. COUNTY DAVIES				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO COUNTY DAVIES			
b. CITY OR TOWN GALLATIN		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) Gallatin		1 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) NANNIE-ANN-WEST			b. (Middle)			c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) 1-1-49							
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2		8. DATE OF BIRTH FEB-23-1861		9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 10 Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MAYSVILLE MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME DAVID TRUEN			13b. MOTHER'S MAIDEN NAME ROLLAND			14. NAME OF HUSBAND OR WIFE WOODSEN WEST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elmer West Winston MO			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senile lateral degeneration ANECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 40				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1945 to Jan. 1 , 19 49 , that I last saw the deceased alive on 1-1- , 19 49 , and that death occurred at 2:20 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Floyd E. Nelson M.D.				23b. ADDRESS Gallatin Mo.		23c. DATE SIGNED Jan 19 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 1-2-49		24c. NAME OF CEMETERY OR CREMATORY WINSTON		24d. LOCATION (City, town, or county) (State) WINSTON MO	
DATE RECD BY LOCAL REG. 16 Feb. 1949		REGISTRAR'S SIGNATURE Virginia M Engacher		25. FUNERAL DIRECTOR'S SIGNATURE 1 Mrs Kate Shoup Winston		ADDRESS MO	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.
working under my personal supervision.

Signed.....
Student Embalmer

Signed *L. O. Rickerson*.....

Licensed Embalmer No. *3302*.....

P. O. Address *Gallatin 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.