

FILED APR 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9027

State File No. ....

BIRTH NO. 49-016242 REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 35

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>LAWRENCE</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>LAWRENCESS</u>   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Aurora</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Aurora</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aurora Hospital</u>  |  | d. STREET ADDRESS (If rural, give location) <u>0</u>  |  |
| 3. NAME OF DECEASED<br>a. (First) <u>STEPH</u> b. (Middle) <u>KENNETH</u> c. (Last) <u>WEST</u>   |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>March 25-1949</u>  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>                | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>INFANT</u>  | 8. DATE OF BIRTH <u>MARCH 25-1949</u>  |
| 9. AGE (In years) (last birthday) <u>0</u> IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min. <u>2</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country) <u>LAWRENCE 0</u>                    |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>LAWRENCE</u>   |  |
| 13a. FATHER'S NAME <u>KENNETH WEST</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Doris STEWART</u>  | 14. NAME OF HUSBAND OR WIFE <u>INFANT</u>                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>   | 17. INFORMANT'S SIGNATURE OR NAME <u>Kenneth West</u> ADDRESS <u>Aurora MO</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory failure from birth</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Impaired placental circulation &amp; anemia</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION <u>1949</u>  |  |
| 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 <u>Nov 25, 1949</u> to <u>Nov 25, 1949</u> , that I last saw the deceased alive on <u>Nov 25, 1949</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above. |  |   |  |
| 23a. SIGNATURE <u>McCallum</u> (Degree or title)  |  | 23b. ADDRESS <u>13 W. Clow Union Hotel</u>  | 23c. DATE SIGNED <u>Nov 25, 1949</u>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 24b. DATE <u>3/26/49</u>                 | 24c. NAME OF CEMETERY OR CREMATORY <u>MARIE PARK</u>  | 24d. LOCATION (City, town, or county) (State) <u>Aurora MO</u>                 |
| DATE REC'D BY LOCAL REG. <u>Mar. 26-49</u>  | REGISTRAR'S SIGNATURE <u>Ora Mc Natt</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Osceola &amp; Main</u> ADDRESS <u>157 0</u>   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10. 48

RECEIVED

District Health Officer No. 8;

District File Number 449-403

Date Filed 4-6-49

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 \_\_\_\_\_

was not embalmed Student Embalmer No. 2  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed Paul S. Marsh

Licensed Embalmer No. 3812

P. O. Address Quincy, 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.