

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41719

BIRTH NO.		REG. DIST. NO. 207		PRIMARY REG. DIST. NO. 5736		Registrar's No. 42	
1. PLACE OF DEATH a. COUNTY Maries				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Maries			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - 41st twship		c. LENGTH OF STAY (in this place) 20yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (41st Township)			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION William				d. STREET ADDRESS (If rural, give location) Jefferson twip			
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) Oliver		c. (Last) West		4. DATE OF DEATH (Month) (Day) (Year) Dec. 13 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH March 10-1885	
9. AGE (In years last birthday) 64		10. MONTHS 9		11. DAYS 3		12. HOURS 0 MIN. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA							
13a. FATHER'S NAME John West		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Sophia West			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mr. Elmer West ADDRESS Bland, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Stroke Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Stroke 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 Instant 4201	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) m.		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 Nov 7, 1949 , to Dec 13, 1949 , that I last saw the deceased alive on Dec 11, 1949 , and that death occurred at 1:00p m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Chas A. Schuch				23b. ADDRESS Gerald 2nd		23c. DATE SIGNED 12-16-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/16/49		24c. NAME OF CEMETERY OR CREMATORY Liberty		24d. LOCATION (City, town, or county) (State) Belle, Maries County-Mo.	
DATE REC'D BY LOCAL REG. 12-22-49		REGISTRAR'S SIGNATURE Pauline Howard		25. FUNERAL DIRECTOR'S SIGNATURE Sassmann's Funeral Service - Belle ADDRESS Chas A. Schuch			

RECEIVED
DEC 28 1949
District Health Officer
District File Number

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 Chester Sassman

Licensed Embalmer No. 4178

P. O. Address Bland - 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.