

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 19 1950

No. 300

10.48

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BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 5529 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheatland-Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheatland Township</u>	
c. LENGTH OF STAY (in this place) <u>23 years</u>		d. STREET ADDRESS (If rural, give location) <u>2 miles North of Wheatland</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2 miles North of Wheatland</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>William</u> c. (Last) <u>West</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 10 - 1950</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN 1 - 1888</u>
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>Macks Creek, Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>George West</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie West, Wheatland, Mo</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>Nellie West, Wheatland, Mo</u> ADDRESS _____
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) <u>Peritonitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 Hours</u> ANTECEDENT CAUSES DUE TO (b) <u>Ulcer of Stomach</u> <u>12 years</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5400</u>	
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) _____		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>March 30, 1927</u> , to <u>Sept 10, 1950</u> , that I last saw the deceased alive on <u>Sept 9, 1950</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>D. E. Briggs, M.D.</u> (Degree or title)		23b. ADDRESS <u>Wheatland, Mo</u>	
23c. DATE SIGNED <u>9-14-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-14-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mission Ridge</u>		24d. LOCATION (City, town, or county) (State) <u>Wabana, Mo</u>	
DATE REC'D BY LOCAL REG. <u>Sept 14 - 1950</u>		REGISTRAR'S SIGNATURE <u>W.P. Hargiss</u> 121	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hathaway</u>		ADDRESS <u>Wheatland</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-18-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 9-18-50

SEP 27 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Chas Gilbert Withaway*

Licensed Embalmer No. *4267*

P. O. Address *Wheatland, Md*

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.