

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40320

BIRTH NO. _____ REG. DIST. NO. 111 PRIMARY REG. DIST. NO. 5426 Registrar's No. 521

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY Phelps	
b. CITY OR TOWN Rural Boles		c. CITY OR TOWN ROLLA	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 305 W. 8th Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) SABOB b. (Middle) Hubert c. (Last) WEST		4. DATE OF DEATH (Month) (Day) (Year) Dec 29 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-16-1889
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Fruit Dealer		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Produce	11. BIRTHPLACE (State or foreign country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME John West		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Geneva West
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 48678-9076	17. INFORMANT'S SIGNATURE OR NAME Geneva West ADDRESS Rolla 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) accidentally Struck By Auto Crossing Hwy 66 on Foot 2/10 Mile West of East Jct. 50 + 66. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above, cause (a) stating the underlying cause last. DUE TO (b) Fracture Neck DUE TO (c) Fracture Both Arms II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. Fracture Both legs Crushed Chest	
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) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hwy 66 + 50	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Boles Franklin Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 29 1950 6:15 PM		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Accident
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Phos. P. Shaffer (Degree or title) Coroner		23b. ADDRESS Rolla Mo	23c. DATE SIGNED 12/29/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-1-51	24c. NAME OF CEMETERY OR CREMATORY Rolla Cemetery	24d. LOCATION (City, town, or county) (State) Rolla Mo
DATE REC'D BY LOCAL REG. 1-1-51	REGISTRAR'S SIGNATURE Mary B. Gross	25. FUNERAL DIRECTOR'S SIGNATURE 94 ADDRESS Null Funeral Home Rolla, Mo	

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

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RECEIVED
JAN 8 1951
DISTRICT HEALTH OFFICE
NO. 4
1951

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.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Geo. L. Shuler*
Licensed Embalmer No. *30005*
P. O. Address *Boaz, Ala.*

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.