

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43000**  
Registrar's No. **10820**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis, Mo.**  
c. LENGTH OF STAY (In this place) \_\_\_\_\_  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis**  
d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Louis City Hospital #1.**  
d. STREET ADDRESS (If rural, give location) **4232a Olive St**

3. NAME OF DECEASED  
a. (First) **JOHN** b. (Middle) \_\_\_\_\_ c. (Last) **WEST**  
4. DATE OF DEATH (Month) (Day) (Year) **Dec. 17th, 1950**

5. SEX **male** 6. COLOR OR RACE **white** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **married**  
8. DATE OF BIRTH **Dec. 17th, 1885** 9. AGE (In years last birthday) **65**  
10a. USUAL OCCUPATION (If the kind of work done during most of working life, even if retired) **none** 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_  
11. BIRTHPLACE (State or foreign country) **St. Louis, Missouri** 12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13a. FATHER'S NAME **John West** 13b. MOTHER'S MAIDEN NAME **unknown** 14. NAME OF HUSBAND OR WIFE **Nevada L. West**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** (If yes, give war or dates of service) \_\_\_\_\_  
16. SOCIAL SECURITY NO. **494-05-6545** 17. INFORMANT'S SIGNATURE OR NAME **Nevada L. West** ADDRESS **4232a Olive St**

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
**MEDICAL CERTIFICATION**  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Arterio Sclerotic Cardiovascular Disease**  
ANTECEDENT CAUSES **Vascular Disease**  
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? **H221**

22. I hereby certify that I attended the deceased from **12/14/50** to **12/17/50**, that I last saw the deceased alive on **12/17/50**, and that death occurred at **4:50am**, from the causes and on the date stated above.

23a. SIGNATURE **R. F. Huck Jr. M.D.** (Degree or title) 23b. ADDRESS **1515 Lafayette Ave.,** 23c. DATE SIGNED **12/18/50**  
24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **12-20-50** 24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis Mo**

DATE REC'D BY LOCAL REG. **DEC 19 1950** REGISTRAR'S SIGNATURE **J. B. Cassen** 25. FUNERAL DIRECTOR'S SIGNATURE **Leidner U.** ADDRESS **2223 St. Louis Ave**

(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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Robert M. Murray*

Signed.....

Student Embalmer

Licensed Embalmer No. *3749*

P. O. Address *St. Louis 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.