

FILED MAY 14 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12304**

**420**

BIRTH NO. _____		REG. DIST. NO. <b>128</b>		PRIMARY REG. DIST. NO. <b>2000</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>1117 W. Harrison</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>MARION</b>		b. (Middle) <b>E.</b>		c. (Last) <b>WEST</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 10 1951</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 11 1892</b>	
9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Zarchira West</b>		13b. MOTHER'S MAIDEN NAME <b>Lula Smith</b>		14. NAME OF HUSBAND OR WIFE <b>Lula West</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Lula West Springfield</b>			
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) <b>Myocardial Infarction</b> ANTECEDENT CAUSES <b>Virus pneumonia</b> Morbid 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 <b>Pleurisy Left chest</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>7 days</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>492x</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <b>5-9-1951</b> , to <b>5-10-1951</b> , that I last saw the deceased alive on <b>5-10-1951</b> , and that death occurred at <b>11:30p.m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE (Degree or title) <b>Robert W. Standley M.D. Med arts Bldg</b>				23b. ADDRESS		23c. DATE SIGNED <b>5-11-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>MAY 13, 1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hazelwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>5-12-51</b>		REGISTRAR'S SIGNATURE <b>W. E. Standley M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. W. Klingner &amp; Co. Springfield</b>			

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

0396

MAY 19 1951

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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.

Student .....  
Student Embalmer

Signed *Max Rhodes*

Licensed Embalmer No. 4071

P. O. Address Springfield, 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.