

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22758**
 BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **732**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 526 Cozy	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 526 Cozy			

3. NAME OF DECEASED (Type or Print)	a. (First) Edith	b. (Middle) Catherine	c. (Last) West	4. DATE OF DEATH (Month) (Day) (Year) July 30, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12 March 1893	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (City and State or Foreign Country) Ft. Smith Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Goodking	13b. MOTHER'S MAIDEN NAME Bernea	14. NAME OF HUSBAND OR WIFE Jessie B. West
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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. No	17. INFORMANT'S SIGNATURE OR NAME Jessie B. West ADDRESS Springfield, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2-3 yr.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial Disease	DUE TO (b) _____		
ANTECEDENT CAUSES	DUE TO (c) _____		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	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 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **2-26, 1953**, to **7-30, 1954**, that I last saw the deceased alive on **6-21, 1954**, and that death occurred at **9:40 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. O. G. (Name or title)	23b. ADDRESS 1711 Boonville Springfield, Missouri	23c. DATE SIGNED 7-30-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE AUG. 1-54	24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 8/2/54	REGISTRAR'S SIGNATURE Edith Williams	FUNERAL DIRECTOR'S SIGNATURE J. W. Clingner ADDRESS B. Springfield, Mo.
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Signed 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Ogle Stone Jr.*

Licensed Embalmer No. *41*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.