

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11636**

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

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 381

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. LENGTH OF STAY (in this place) 4 months	c. CITY OR TOWN Springfield,	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Greene County Hospital		e. STREET ADDRESS (If rural, give location) 2909 W. Hovey	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Samuel c. (Last) Westmoreland			4. DATE OF DEATH (Month) (Day) (Year) April 29, 1955		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 22, 1870	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 3 Days 7	IF UNDER 4 HRS. Hours 7 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and State or Foreign Country) Ozark County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James S. Westmoreland	13b. MOTHER'S MAIDEN NAME Sadie	14. NAME OF HUSBAND OR WIFE Levie C. Westmoreland
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME E. L. Westmoreland		ADDRESS Springfield,	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			Mo.	INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	High Blood Pressure				
*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	DUPLICATE (b)	DUPLICATE (c)		
	Conditions contributing to the death but not related to the disease or condition causing death.	Artero-Sclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (m.)	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 1-16-1955, to 4-29-1955, that I last saw the deceased alive on 4-29-1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

23a. SIGNATURE W. L. Willy MD	(Degree or title) MD	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 5-2-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 2, 1955	24c. NAME OF CEMETERY OR CREMATORY Cardwell	24d. LOCATION (City, town, or county) (State) Fordland, Missouri
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DATE REC'D BY LOCAL REG. 5-3-55	REGISTRAR'S SIGNATURE Paul Williams	25. FUNERAL DIRECTOR'S SIGNATURE Gorman-Scharpf Funeral Home, Inc.		ADDRESS Springfield, Missouri	
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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.....
Signature of Student Embalmer

Signed *Louis G. Schaff*.....

Licensed Embalmer No. *3802*.....

P. O. Address *Springfield*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.