

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3491

State File No.

FILED JAN 20 1956 REG. DIST. NO. 325 PRIMARY REG. DIST. NO. 6098 Registrar's No. 39

1. PLACE OF DEATH
a. COUNTY *Schuyler*

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE *Missouri* b. COUNTY *Schuyler*

b. CITY OR TOWN *Liberty* c. LENGTH OF STAY (in this place)
c. CITY OR TOWN *LANCASTER* d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION e. STREET ADDRESS (If rural, give location)
Liberty *0980*

3. NAME OF DECEASED a. (First) *HELEN* b. (Middle) *MARIE* c. (Last) *West* 4. DATE OF DEATH (Month) (Day) (Year)
JAN. 9 56

5. SEX *F* 6. COLOR OR RACE *W* 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) *MARRIED* 8. DATE OF BIRTH *Dec 5 1920* 9. AGE (In years last birthday) *36* 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *HOUSEWIFE* 11. BIRTHPLACE (City and State or Foreign Country) *Missouri* 12. CITIZEN OF WHAT COUNTRY? *USA*

13a. FATHER'S NAME *William W Current* 13b. MOTHER'S MAIDEN NAME *SARAH WEST* 14. NAME OF HUSBAND OR WIFE *William T West*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME ADDRESS
William T West Lancaster 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) *Melanoma Sarcoma* INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DUE TO (b) *(Pulmonary)*
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) *Deeply foken of Mayo's in May 1955 to confirm diagnosis*

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 *163x* 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) m. 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 3, 1955*, to *Jan 9, 1956*, that I last saw the deceased alive on *Jan 9, 1956*, and that death occurred at *12:35 pm*, from the causes and on the date stated above.

23a. SIGNATURE *J. Davidson* (Degree or title) 23b. ADDRESS *Lancaster Mo* 23c. DATE SIGNED *1-9-56*

24a. BURIAL CREMATION, REMOVAL (Specify) *Burial* 24b. DATE *Jan 11-56* 24c. NAME OF CEMETERY OR CREMATORY *L.P.O.F.* 24d. LOCATION (City, town, or county) (State) *Lancaster Mo*

DATE REC'D BY LOCAL REG. *Jan 11 1956* REGISTRAR'S SIGNATURE *353* 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Marchand-Norman Lancaster

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Nora E. Foster*
Licensed Embalmer No. *474*
P. O. Address *Kirkville,*

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.