

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **8180**

FILED MAR 22 1957

Registration District No. 114 Primary Registration District No. 4185 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>FRANKLIN</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SULLIVAN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>SULLIVAN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>47 E. WASHINGTON</b>			Length of stay in lb <b>16 YRS.</b>		d. STREET (If outside, give location) ADDRESS <b>47 E. WASHINGTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES EDWARD WEST</b>				4. DATE OF DEATH <b>MARCH 12 1957</b>			
5. SEX <b>0</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 13, 1881</b>		9. AGE (In years last birthday) <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VARIED</b>		11. BIRTHPLACE (City and state or country) <b>SULLIVAN, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC WEST</b>				14. MOTHER'S MAIDEN NAME <b>MARY RECORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>490-28-6656</b>		17. INFORMANT <b>LAURA WEST, SULLIVAN, MO</b>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		STATE	
21. I attended the deceased from <b>10/15/56</b> to <b>3/12/57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>3/9/57</b> . Death occurred at <b>10 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ronald K. Heath MD</b>				22b. ADDRESS <b>Sullivan, Mo</b>		22c. DATE SIGNED <b>3/14/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>BURIAL</b>		<b>MARCH 16, 1957</b>	<b>I. O. O. F. CEMETERY</b>		<b>SULLIVAN MO.</b>		
24. FUNERAL DIRECTOR <b>H McEaton</b>			ADDRESS <b>Sullivan, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>3/15/57</b>	26. REGISTRAR'S SIGNATURE <b>Thomas G. Humphrey</b>	

(Licensed Embalmer's Statement on Reverse Side)

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Use only black ink or ribbon typewrite if possible. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. A. Dempsey*.....

Licensed Embalmer No. *477*

P. O. Address *Sullivan, N.Y.*

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.