

FILED SEP 3 1957

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

 '57 027773  
 STATE FILE NUMBER

 Registration District No. 64 Primary Registration District No. 5245 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Keokosville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Mendon</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chariton County Rest Home</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>22 B</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>D</u> Last <u>West</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>M</u>	16. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23-1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>physician</u>	9. AGE (In years last birthday) <u>87</u>
13. FATHER'S NAME <u>John W West</u>		11. BIRTHPLACE (City and state or country) <u>Chariton Co MO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
17. INFORMANT <u>J. G. West BELLEVILLE</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA M. THOMAS</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility in bed several months</u>			
DUE TO (c) <u>3 years he did not know his name</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>his name</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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.) <u>304X</u>
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u>			
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 COUNTY STATE
21. I attended the deceased from <u>July 20</u> to <u>Aug 22-57</u> and last saw her alive on <u>Aug 22-57</u> Death occurred at <u>700 W</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>D. F. Fife D O</u>		22b. ADDRESS <u>Brunswick Mo</u>	22c. DATE SIGNED <u>8/24/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8/25/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rothville</u>	23d. LOCATION (City, town, or county) (State) <u>Rothville Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>D. H. Ripard Mendon MO</u>		25. DATE RECD. BY LOCAL REG. <u>8/26/57</u>	26. REGISTRAR'S SIGNATURE <u>W. H. Hastings</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard forms. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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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 *A. P. Leonard*

Licensed Embalmer No. 39

P. O. Address *Mendon*

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.