

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005052

STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. 119 Primary Registration District No. 4191 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GASCONADE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GASCONADE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>v</u>		Length of stay in 1b <u>354rs</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u>ANN</u> Last <u>WEST</u>	4. DATE OF DEATH Month <u>FEB</u> Day <u>21</u> Year <u>1958</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7-1878</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HomeWORK</u>	11. BIRTHPLACE (City and state or country) <u>COOPER HILL Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>ANDY CARWILE</u>	13b. MOTHER'S MAIDEN NAME <u>MAHALIA JETT</u>	14. NAME OF HUSBAND OR WIFE <u>BAYLESS WEST</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. ARTHUR ENGLETT GASCONADE Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF GALL BLADDER</u> <u>&amp; METASTASES TO LIVER</u> 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) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>1551</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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from 1954 to 2-21-58 and last saw <sup>her</sup> <sub>him</sub> alive on 2-20-58  
Death occurred at 6 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>George M. Workman M.D.</u>	22b. ADDRESS <u>HERMANN, MO</u>	22c. DATE SIGNED <u>2-22-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/23/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GASCONADE Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>GASCONADE Mo</u>
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24. FUNERAL DIRECTOR <u>HUGO H. BLUMER</u>	ADDRESS <u>HERMANN Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no relation. All diseases in Part I must be causally related.

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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 Roger W. Blumer, Student Embalmer No. 553 working under my personal supervision.

Student *Roger W. Blumer*  
Signature of Student Embalmer

Signed *Hugo St. Blumer*

Licensed Embalmer No. 3160  
P. O. Address *Hermann*

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.