

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022185  
STATE FILE NUMBER

FILED JUN 25 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 267

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1-57  
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1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</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>KIRBY NURSING</b>		Length of stay in lb <b>2 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>1119 EAST 8TH STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>MABLE</b> Last <b>WEST</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 17, 1880</b>		9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOKING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANTS</b>		11. BIRTHPLACE (City and state or country) <b>BREEZE, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
14. NAME OF HUSBAND OR WIFE <b>JOHN M. WEST</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>495-20-2632</b>		17. INFORMANT <b>MRS. ELIZABETH PELLETIER</b>		Address <b>LEES SUMMIT</b>	

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>Circulatory Failure</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b>		
	DUE TO (c) <b>Lues</b>	<b>029X</b>	
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? 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 <b>-</b> Month, Day, Year a.m. <b>-</b> p.m. <b>-</b>			

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 <b>INDEPENDENCE</b>	COUNTY <b>MO</b>	STATE <b>MO</b>
21. I attended the deceased from <b>Dec 6 1957</b> to <b>April 29, 1958</b> last saw her alive on <b>April 29, 1958</b> Death occurred at <b>12:25</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <b>E. H. Stults DO</b> (Degree or title)		22b. ADDRESS <b>401 W. Truman</b> DATE SIGNED <b>6-20-58</b>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JUNE 21, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BROOKINGS, CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>RAYTOWN, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>C. A. Blackman - Son Inc.</b> ADDRESS <b>15 P. Th.</b>	25. DATE RECD. BY LOCAL REG. <b>6-21-58</b>	26. REGISTRAR'S SIGNATURE <b>James S. Gray</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Student .....  
Signature of Student Embalmer

Signed ..... *But B. Benn*

Licensed Embalmer No. *4656*

P. O. Address *14. C., Md*

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.