

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034818  
Star File No.

FILED SEP 29 1958

BIRTH NO. 62012 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8774

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>CLAYTON-5</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>JEANSH HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>27 6454 ALAMO</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>West</u> b. (Middle) <u>WEST</u> c. (Last) <u>WEST</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-12-58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>8-12-58</u>
9. AGE (In years last birthday) <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	

11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>JOHN ROGER WEST</u>		13b. MOTHER'S MAIDEN NAME <u>CAROL H. KETCHAM</u>		14. NAME OF HUSBAND OR WIFE	
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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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CAROL WEST, 6454 ALAMO CLAYTON-5 MO</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)		<u>776x</u>	
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		20. AUTOPSY? <u>Y</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 8-12, 1958, to 8-12, 1958, that I last saw the deceased alive on 8-12, 1958, and that death occurred at 9:00 P. m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>Seymour Mont MD</u>		23b. ADDRESS <u>100 No Euclid</u>		23c. DATE SIGNED <u>8-27-58</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-30-58</u>		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>SEP 1 1958</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Akers 4109 Manchester</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

Licensed Embalmer No.....

P. O. Address .....

**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.