

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021041
STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 674

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1618 E Atlantic		Length of stay in lb 1 week	
d. STREET ADDRESS 634 R. 4 Box 546 West		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ZETTA ADELINE WEST			4. DATE OF DEATH Month Day Year June 20, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19, 1873	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Harrison, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Payton Burrow	13b. MOTHER'S MAIDEN NAME Sally Ruckman	14. NAME OF HUSBAND OR WIFE John Marion West
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Eugene West R. 4 Box 546 Sngld Mo.
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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) Circulatory failure (decompensated cor pulmonale)		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Mitral stenosis	
	DUE TO (c) Inactive rheumatic fever	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410X		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 June 7, 1957 to June 20, 1959 and last saw her alive on June 20, 1959 Death occurred at 2:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) R. F. Hedgcock D.O. 2	22b. ADDRESS 617 S. Scenic, Springfield, Missouri	22c. DATE SIGNED 6/26/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 22, 59	23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery	23d. LOCATION (City, town, or county) (State) Bois D' Arc, Mo.
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24. FUNERAL DIRECTOR ADDRESS Daniel - Daniel - Ash Grove - 29-59	25. DATE RECD. BY LOCAL REG. 6/26/59	26. REGISTRAR'S SIGNATURE Effie B. Melton
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL diseases in Part I must be causally related.

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 *Sage L. Davis*

Licensed Embalmer No. *4702*

P. O. Address *Alh. Grove*

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.