

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025501

FILED VS JUL 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3327

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-57

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>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lees Summit</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>VA Hospital, K.C.Mo.</b>		Length of stay in lb. <b>13 days</b>	7000 STREET ADDRESS (If outside, give location) <b>P. O. Box 181</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First **ELIJAH** Middle **JOSHUA** Last **WEST** 4 Miles North Lee's Summit  
DATE OF DEATH **7-5th 1959**

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/91</b>	9. AGE (In years last birthday) <b>67</b>	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) <b>unemployed Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state or country) <b>Linn Creek, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John W. West</b>	13b. MOTHER'S MAIDEN NAME <b>Lucida Jackson</b>	14. NAME OF HUSBAND OR WIFE <b>Annie West</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWT</b>	16. SOCIAL SECURITY NO. <b>498-10-8535</b>	17. INFORMANT <b>VA HOSPITAL RECORDS, K. C. MO.</b> Address
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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) **Subarachnoid hemorrhage**  
INTERVAL BETWEEN ONSET AND DEATH **36 hours**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }  
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)  
**Arteriosclerotic Heart Disease** **330X**

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. 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 _____
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21. Attended the deceased from **6/22/59** to **7/5/59**  
Death occurred at **7:30 a.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Stanley R. Shane</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VA Hospital, K. C. MO.</b>	22c. DATE SIGNED <b>7/5/59</b>
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23a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>	23b. DATE <b>July 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Summit, Missouri</b>	23d. LOCATION (City, town, or county) (State) <b>Lee's Summit, Missouri</b>
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24. FUNERAL DIRECTOR <b>Langsford Funeral Home, Lee's Summit</b>	25. DATE RECD. BY LOCAL REG. <b>7-7-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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Stanley R. Shane USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MO.

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 *N.B. Langford* .....

Licensed Embalmer No. *3833* .....

P. O. Address *Jessie Sumner* .....

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.