URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1959 38

59-028202
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 408

NDED

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia Township
Length of stay in 1b: 7 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rsdn. Columbia ~~Township~~
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Boone
c. CITY OR TOWN Sturgeon, Mo. Star Rt.
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Rocky Fork Twp.
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First John Middle Last West
4. DATE OF DEATH: Month August Day 29 Year 1959
5. SEX: Male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Aug 9, 1886
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months 0 Days 20 IF UNDER 24 HR: Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad worker
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Mark Tree, Ark.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William West
13b. MOTHER'S MAIDEN NAME: Ann (Unknown)
14. NAME OF HUSBAND OR WIFE: Myrtle C. West
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 702-07-3439
17. INFORMANT: Mrs. Geo. A. Seiler, Address: Star Rt, Sturgeon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, Acute — INTERVAL BETWEEN ONSET AND DEATH: 30-45 Min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — More than 3 years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from January 3, 1959 to August 29, 1959 and last saw ~~him~~ alive on June 13, 1959
Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John C Tinsley Jr M.D.
22b. ADDRESS: 16 So. Tenth Columbia, Mo
22c. DATE SIGNED: 8-29-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 1, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Horeb Cemetery
23d. LOCATION (City, town, or county) (State): Sturgeon Mo.

24. FUNERAL DIRECTOR: Bill Jr Mfg Sturgeon Mo
ADDRESS
25. DATE RECD. BY LOCAL REG.: Sept 1, 1959
26. REGISTRAR'S SIGNATURE: Mrs R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

SEP 8 1959

US NOV 25 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Bill J. Meador

Signature of Student Embalmer

Licensed Embalmer No. 4876

P. O. Address Sturgeon, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.