

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040457

FILED VS. DEC 10 1959 149

Primary Registration District No. 1002 Registrar's No. 5570

STATE FILE NUMBER

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>		Length of stay in 1b <b>74 Years</b>		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>St. Joseph Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4233 Wyoming</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>W</b> Last <b>WEST</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> , Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</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>Jan 19, 1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Proctor &amp; Gamble</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Charles F. West</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Mrs. Flora G. West</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>510-05-2384</b>		17. INFORMANT Address <b>Mrs. Flora G. West, 4233 Wyoming K.C. Mo.</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>Peritonitis</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>Post-Colectomy necrosis of the Sigmoid</b>							
		DUE TO (c) <b>Anastomosis; Hypostatic Pneumonia</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary Emphysema; Prostatic Hypertrophy</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year							
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	
21. I attended the deceased from <b>April 3, 1959</b> to <b>11-16-59</b> and last saw her/him alive on <b>11-16-59</b> Death occurred at <b>10:05 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Leo F. Cooper</b> (Degree or title)				22b. ADDRESS <b>1220 E 31st K.C., MO</b>				22c. DATE SIGNED <b>11-16-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Muehlebach 6800 Troost</b>				25. DATE RECD. BY LOCAL REG. <b>11-18-59</b>		26. REGISTRAR'S SIGNATURE <b>Mewa Minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Leo F. Cooper

**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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address 91 E. 7th

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.