

FILED VS NOV 19 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-042701

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

210201

Registrar's No.

V. S. 300  
Rev. 1-57  
92  
118/1

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Peoples Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4239 Enright Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Amy</b> Middle <b>Westfall</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1874</b>
9. AGE (In years last birthday) <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Scott County, Mississippi</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Dudley Russell</b>	
13b. MOTHER'S MAIDEN NAME <b>Katherine Mays</b>		14. NAME OF HUSBAND OR WIFE <b>Reuben Westfall (dec'd)</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.	
17. INFORMANT <b>Carl Westfall</b>		Address <b>4045 Cottage Avenue</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>Gangrenous appendicitis</b> <b>infection &amp; interference with blood supply of appendix</b> DUE TO (b) <b>Intake acid interference</b> DUE TO (c) <b>with blood supply of Appendix</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Patients age</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>550.1</b>		20c. TIME OF INJURY Hour Month, Day, Year 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	
21. I attended the deceased from <b>Oct 29-59</b> to <b>NOV. 4-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>NOV. 4-59</b> Death occurred at <b>9 a.m.</b> <b>PA</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. N. Vaughn</b> (Degree or title) <b>A. N. Vaughn M.D.</b>		22b. ADDRESS <b>1123a Union</b> <b>1123a Union Blvd.</b>	
22c. DATE SIGNED <b>Nov. 5-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>11-7-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Alton, Illinois</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>Russell Und., Co.</b>		ADDRESS <b>2732 Pine Street</b>	
25. DATE RECD. BY LOCAL REG. <b>NOV 6 1959</b>		26. REGISTRAR'S SIGNATURE <b>Roal Smith M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

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 James A. Carter

Licensed Embalmer No. 4681

P. O. Address ..... mo.

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.