

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005767

FILED VS MAR 7 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 40

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>WASHINGTON</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>SULLIVAN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. R. 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WEST</u> Last <u>WEST</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>27</u> Year <u>1960</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1892</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECTION HAND</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (City and state or country) <u>SULLIVAN MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ISAAC WEST</u>	13b. MOTHER'S MAIDEN NAME <u>MARY RECORD</u>	14. NAME OF HUSBAND OR WIFE <u>DIVORCED</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>LUKU WEST SULLIVAN, MO</u> 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) <u>Cardiac Decompensation</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>General arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Heart Disease</u> <u>4 yrs.</u> <u>4 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART (a) <u>Viridans Pneumonitis</u>		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
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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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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 <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from <u>Aug 1954</u> to <u>2/27/60</u> and last saw her/him alive on <u>2/26/60</u> Death occurred at <u>6:25</u> A.m. on the date stated above, and to the best of my knowledge, from the cause stated.	
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22a. SIGNATURE (Degree or Title) <u>John J. Gata, M.D.</u>	22b. ADDRESS <u>1011 S. Sullivan, Mo.</u>	22c. DATE SIGNED <u>2/27/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MARCH 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BUFFALO CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>SULLIVAN MO</u>
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24. FUNERAL DIRECTOR <u>H. M. EATON</u> ADDRESS <u>SULLIVAN, MO</u>	25. DATE RECD. BY LOCAL REG. <u>3/29/60</u>	26. REGISTRAR'S SIGNATURE <u>F. L. Wideman, Registrar</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 8 1961

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

Samuel N. Eaton

Licensed Embalmer No. 5066

P.O. Address Sullivan, TN

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.