

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018001

FILED VS MAY 2 1960

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 83 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>7 yrs</u>	c. CITY OR TOWN <u>Joplin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Marshall State School &amp; Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1320 Iowa St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>To</u> Last <u>West</u>			4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-20-1943</u>	9. AGE (last birthday) <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>patient</u>		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <u>Joplin, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William A. West</u>		13b. MOTHER'S MAIDEN NAME <u>Sadie ? West</u>		14. NAME OF HUSBAND OR WIFE -----	
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>None</u>	17. INFORMATION Address <u>Marshall State School &amp; Hosp. Marshall, Mo.</u>		
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>Broncho-pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
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) <u>Chronic invalid of idiot mentality</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>April 1, 1958</u> to <u>Apr. 23, 1960</u> and last saw her/him alive on <u>4-23-1960</u> Death occurred at <u>3:45 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>A. B. Day</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Marshall State School &amp; Hosp. Marshall Mo.</u>		22c. DATE SIGNED <u>4-25-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Joplin Mo</u>		
24. FUNERAL DIRECTOR <u>Harry Idenberger</u>		ADDRESS <u>Marshall Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-25-'60</u>	26. REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Signature of Student Embalmer

Signed Harry Herskberger

Licensed Embalmer No. 4357

P. O. Address Marshall

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.