

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018306

FILED VS MAY 23 1960 **30**

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. **4038** Registrar's No. **24**

1. PLACE OF DEATH a. COUNTY <u>Benton</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warsaw</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Benton</u> c. CITY OR TOWN <u>Warsaw</u> d. STREET ADDRESS (If outside, give location) _____							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tannie Bell West</u>				4. DATE OF DEATH Month Day Year <u>May 19 1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13 1898</u>		9. AGE (last birthday) <u>66</u> IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> IF UNDER 24 HR: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>De Kalb Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Robert Bird</u>			13b. MOTHER'S MAIDEN NAME <u>Emiline Thompson</u>			14. NAME OF HUSBAND OR WIFE <u>L. J. West</u>					
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>491-22-0267</u>		17. INFORMANT Address <u>L. J. West Warsaw, 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>MEDULLARY PARALYSIS</u> DUE TO (b) <u>THROMBOTIC ENCEPHALOMALACIA WITH CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>2 WKS.</u> <u>3 YRS.</u>			
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. <input type="checkbox"/> Yes <input 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 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>MAY 12, 1960</u> to <u>MAY 19, 60</u> and last saw her him alive on <u>MAY 18, 1960</u> Death occurred at <u>8:30 A M</u> <u>4</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Deceased or title) <u>Eussally DO</u>				22b. ADDRESS <u>Warsaw Mo.</u>				22c. DATE SIGNED <u>5-20-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 22 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shombough Cem Co.</u>		23d. LOCATION (City, town, or county) (State) <u>De Kalb Co, Mo</u>					
24. FUNERAL DIRECTOR ADDRESS <u>John J. Reser Warsaw</u>				25. DATE RECD. BY LOCAL REG. <u>May 20 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Yas. A. Logan.</u>					

ENDED

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed John F. Reser

Licensed Embalmer No. 409

P. O. Address Warsaw

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.