

Dept. Health,
& Welfare
S. Public
Health Service

S. 300
ev. 1-57

FILED VS JUL 6 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-022702

STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 5322 Registrar's No. 18-1960

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Benton Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u> <u>Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>		Length of stay in 1b <u>11 Years</u>	d. STREET ADDRESS (If outside, give location) <u>Maple shade Rd.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>MAY</u> Last <u>WEST</u>			4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>		
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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>Oct 29 1887</u>	9. AGE (In years) Last birthday <u>72</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u>	IF UNDER 24 HRS. 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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Cuba (Oak Hill) Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Alva C. Ryerson</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Susan Keffer</u>	14. NAME OF HUSBAND OR WIFE <u>William West</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>William West</u>	Address <u>Cuba, Mo.</u>
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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>Acute Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Atherosclerosis</u>		
DUE TO (c) <u>4201</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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> Month, Day, Year a.m. <u></u> p.m. <u></u>	
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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 <u>Cuba</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>June 1960</u> and last saw <u>her</u> alive on <u>May 20 1960</u> Death occurred at <u>1:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank A. Elders M.D.</u> (Degree or title)	22b. ADDRESS <u>Cuba, Mo.</u>	22c. DATE SIGNED <u>6-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK Hill</u>	23d. LOCATION (City, town, or county) <u>Cuba</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Norman C. Hoerter</u>	ADDRESS <u>Cuba, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-25-1960</u>	26. REGISTRARS SIGNATURE <u>Frank A. Elders</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Norman R. Hoener*

Licensed Embalmer No. *4673*

P. O. Address *Cuba, 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.