

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-034490**

**FILED VS. OCT 3 1960**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 926A STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Burge Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D. # 5</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>M.</b> Last <b>WEST</b>			4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. employee</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>seed Company</b>	11. BIRTHPLACE (City and state or country) <b>Osage, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Andrew West</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Jones</b>	14. NAME OF HUSBAND OR WIFE <b>Ethyl West</b>
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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) <b>No None</b>	16. SOCIAL SECURITY NO. <b>431-16-7167</b>	17. INFORMANT Address <b>Ethyl West, Rt. 5, Springfield, Mo.</b>
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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) <b>Likely Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
DUE TO (b) <b>Likely Coronary Sclerosis</b>		<b>Unknown</b>
DUE TO (c) <b>UNATTENDED BY A PHYSICIAN</b>		

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
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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 _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at **9:30 A.M.** on \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <b>James P. Thomas, M.D.</b> (Degree or title)	22b. ADDRESS <b>Greene County Health Officer, Spfld Mo</b>	22c. DATE SIGNED <b>9-26-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/7/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>East Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>Ralph Thieme, Springfield, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>9-26-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>
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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 Geetha Collier

Licensed Embalmer No. 363  
P. O. Address Spring

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.