

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-041292  
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 477

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in 1b <b>20 Days</b>	c. CITY OR TOWN <b>Mound City</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>Southeast Missouri Hospital</b>		Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>309 Diamond Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Herron</b> Last <b>West</b>			4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/2/1903</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Clarksdale, Miss.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Frank Morris</b>		13b. MOTHER'S MAIDEN NAME <b>Millie Fox</b>		14. NAME OF HUSBAND OR WIFE <b>Edward West</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>325-18-7501</b>		17. INFORMANT <b>367 Walnut Street</b> <b>Caldonia Noble, Buffalo, New York</b>		

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>Carcinoma - Widespread metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7.6-8 mo.</b>
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)		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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>30 Oct 60</b> to <b>11-20-60</b> and last saw her alive on <b>11-19-60</b>		Death occurred at <b>11:25 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <b>Harold H. King MD.</b>		22b. ADDRESS <b>Cape Girardeau, Mo.</b>		22c. DATE SIGNED <b>30 Nov 60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/24/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spencer Heights</b>	23d. LOCATION (City, town, or county) (State) <b>Mounds, Illinois</b>	
24. FUNERAL DIRECTOR <b>Edward A. Coffey</b>		25. DATE RECD. BY LOCAL REG. <b>11-30-60</b>	26. REGISTRAR'S SIGNATURE <b>Lrene Kasten</b>	

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

DEC 5 1960

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X  
X

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VI  
J. anti. Juni.  
of

FEB 21 1962

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 Edward A. Ruffin

Licensed Embalmer No. 5022  
2501 Poplar Street  
P. O. Address Cairo, Illinois

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.