

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 14 1960

760-044384 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11440

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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>            |  | Length of stay in lb   | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>city Hosp.</u> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      | d. STREET ADDRESS (If outside, give location) <u>3210 Park Ave</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle Last <u>West</u> | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>26</u> Year <u>60</u> |
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|                 |                           |   |                                  |                                  |                                |                              |
|-----------------|---------------------------|---|----------------------------------|----------------------------------|--------------------------------|------------------------------|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-23-82</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------|---------------------------|---|----------------------------------|----------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Confectionary</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Store Keeper</u> | 11. BIRTHPLACE (City and state or country) <u>Tenn.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Wiley West</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Clarence West</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>496-36-3647</u> | 17. INFORMANT Address <u>Clarence West 3210 Park Ave</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)                                   | <u>334 x</u>                     |

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| 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.<br><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<br>Hour a.m. p.m.<br>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 7:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Patrich E Taylor Corner</u> | 22b. ADDRESS <u>1300 Clark</u> | 22c. DATE SIGNED <u>11-28-60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>11-30-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>McLaughlin 2301 Lafayette Ave</u> | 25. DATE RECD. BY LOCAL REG. <u>NOV 28 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> |
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DOCUMENT

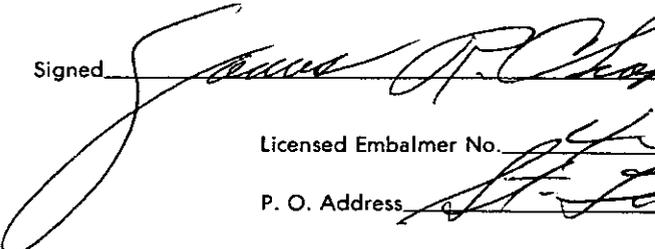
MEDICAL CERTIFICATION

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  \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.