

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004484

Registration District No. 002 Primary Registration District No. 5019 Registrar's No. 7

STATE FILE NUMBER

FILED VS FEB 27 1961

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rochester Township</u>		c. CITY OR TOWN <u>Amazonia</u>	
Length of stay in lb <u>1 day</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shady Lawn</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jess</u> Middle <u>Lawrence</u> Last <u>West</u>			4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1961</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-88</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and state or country) <u>Davis County, Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Abraham West</u>	
13b. MOTHER'S MAIDEN NAME <u>Annie Wallace</u>		14. NAME OF HUSBAND OR WIFE <u>- - - -</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.	
17. INFORMANT <u>William West, Amazonia, Missouri</u>		Address	

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>UREMIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>HYPERTROPHY OF PROSTATE</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MICROCYTIC HYPO-CHROMIC ANEMIA</u>			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 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. attended the deceased from <u>5-13-57</u> to <u>2-6-61</u> and last saw him alive on <u>2-5-61</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>Warren C. Hawkins MD</u> (Degree or title)		22b. ADDRESS <u>SAVANNAH, MISSOURI</u>	22c. DATE SIGNED <u>2-7-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-9-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Amazonia Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Amazonia, Missouri</u>
24. FUNERAL DIRECTOR <u>BREIT & HAWKINS</u> ADDRESS <u>SAVANNAH</u>		25. DATE RECD. BY LOCAL REG. <u>2-13-61</u>	26. REGISTRAR'S SIGNATURE <u>Killian Sparks Reay</u>

(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.