

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013573

STATE FILE NUMBER

AMENDED

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 68

FILED MAY 8 1961

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Howell</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> COUNTY <u>Howell</u>                                       |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>   |  | Length of stay in 1b <u>70 yrs</u>   | c. CITY OR TOWN <u>West Plains,</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>West Plains Memorial</u>  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>813 Webster</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>MARTIN</u> Last <u>WEST</u>   |  | 4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1961</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH <u>5-19-1888</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk and Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Political</u>   | 9. AGE (last birthday) <u>72</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u> IF UNDER 24 HR Hours <u>7</u> Min. <u></u>                          |
| 11. BIRTHPLACE (City and state or country) <u>Horse Cave, Kentucky</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>   |   |
| 13a. FATHER'S NAME <u>Claude C. Martin</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Radford</u>  | 14. NAME OF HUSBAND OR WIFE <u>Arthur H. West</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. <u></u>  |   |
| 17. INFORMANT <u>Prepared own obituary</u>   |  | Address <u></u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Poisoning</u><br>DUE TO (b) <u>Bichloride of Mercury ingestion</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u><br><u>6 hours</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced osteoarthritis. Hypertension</u>   |  | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>   |   |
| 20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>  |  | 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.) <u></u>   |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>  |   |
| 21. I attended the deceased from <u>1955</u> to <u>4/26/61</u> and last saw her alive on <u>4/26/61</u><br>Death occurred at <u>4</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |  |   |
| 22a. SIGNATURE (Degree or title) <u>M.L. Fowler MD</u>   |  | 22b. ADDRESS <u>West Plains Mo.</u>  | 22c. DATE SIGNED <u>5/1/61</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>April 29-61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>   | 23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>   |
| 24. FUNERAL DIRECTOR ADDRESS <u>Carter Funeral Home, West Plains, Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG. <u>5-2-61</u>   | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>  |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Richard Carter*

Licensed Embalmer No.

4516

P. O. Address

*West Plains, 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.