

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-047274

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6273 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 26 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>32 yrs.</b>	c. CITY OR TOWN <b>Kansas 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>NOA Trinity Lutheran</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>609 1/2 E. 31 St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Claude F. West</b>			4. DATE OF DEATH Month Day Year <b>12 8 1962</b>
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>10-14-1909</b>
9. AGE (last birthday) <b>53</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bottle Filler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	11. BIRTHPLACE (City and state or country) <b>Comanche, Texas</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>David M. West</b>	
14. MOTHER'S MAIDEN NAME <b>Cora Ann Nelson</b>		14. NAME OF HUSBAND OR WIFE <b>Nila M. 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>[Redacted]</b>	
17. INFORMANT <b>Nila West</b>		Address <b>609 1/2 E. 31 St. KCMo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion - massive</b>			INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arterio-sclerosis - generalized ? yrs</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) <b>Had had recent small stroke; a less recent coronary.</b>			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 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. I attended the deceased from <b>July - 1957</b> to <b>Dec. 1962</b> and last saw her/him live on <b>Dec 3 - 1962</b> Death occurred at <b>2:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. Paul Wright M.D.</b>		22b. ADDRESS <b>1724 Prof. Kelly Kansas City, Mo.</b>	
22c. DATE SIGNED <b>Dec 10 '62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mellody-McGilley-Eylar 20 West Linwood</b>		25. DATE RECD. BY LOCAL REG. <b>12-10-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

**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 Frederic F. Dickson

Licensed Embalmer No. 5120

P. O. Address K. C. 11, 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.