

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029603

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 914 Primary Registration District No. 4458 Registrar's No. 43

STATE FILE NUMBER

FILED JUL 31 1963

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Osage River</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Green</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>937 West Chestnut</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED First Middle Last <u>Julius Russell West</u>			4. DATE OF DEATH Month Day Year <u>July 24, 1963</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-5-30</u>	9. AGE (last birthday) <u>33</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Stoutland Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Bert West</u>			13b. MOTHER'S MAIDEN NAME <u>Isabelle Campbell</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>Yes WW# 2</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) <u>Drowned While Swimming In Osage River</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
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 type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Stated on line 18 B</u>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year <u>4:00 P.M. 7-24-63</u>			

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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>Osage River</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Osceola St. Clair, Missouri</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>4:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Ruth Seewers Local Reg</u>	22b. ADDRESS <u>Osceola Missouri</u>	22c. DATE SIGNED <u>7/24/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/29/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Goodrich Funeral Home, Osceola Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1 1930
 2 0397
 3
 4 0
 5 3
 6
 7 0
 8 0
 9 298
 10 42
 11 693
 12 918
 13 20
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 USE BLACK INK OR TYPEWRITER RIBBON

AUG 7 1963

AUG 7 1963

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 Paul Thompson

Licensed Embalmer No. 3990

P. O. Address Okla. 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.