MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-042471 STATE FILE NUMBER

Registration District No. 336 Primary Registration District No. 6137 Registrar's No. 291

DO NOT WRITE ON THIS STUB

AMENDED FILED NOV 12 1965

VS 300
Rev. 4/59

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1	1010		
2	1010		
3			
4	0		
5	1		
6			
7	1		
8	0		
9	151X		
10			
11			
12	90-0		
13	1-2		

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Shannon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN:
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Mo b. COUNTY: Shannon
c. CITY OR TOWN: Winona Mo
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Art Middle: Last: West

4. DATE OF DEATH: Month: October Day: 23 Year: 1965

5. SEX: M

6. COLOR OR RACE: W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 12 9-91

9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Columbus, Ind

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Wesley West

13b. MOTHER'S MAIDEN NAME: Vada Goble

14. NAME OF HUSBAND OR WIFE: Allie West

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 490-11-1179

17. INFORMANT Address: Allie B West

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perotinitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of the Stomach
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Oct 1, 1965 to Oct 23 1965 and last saw her/him alive on Oct 18th 1965
Death occurred at 10. P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. H. Rathin MD

22b. ADDRESS: Winona Mo

22c. DATE SIGNED: 10-30-65

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Oct 26 1965

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

23d. LOCATION (City, town, or county) (State): Winona Mo

24. FUNERAL DIRECTOR ADDRESS: Duncan Funeral Home Mt View Mo

25. DATE RECD. BY LOCAL REG.: Nov. 1965

26. REGISTRAR'S SIGNATURE: Mabel Rollins

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____
Signature of Student Embalmer

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.