

DEC 20 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County CarrollRegistration District No. 133Township VanhookPrimary Registration District No. 4074City Boyard

(No. _____)

File No. 35550Registered No. 22

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. James E. Worth St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

- Emma Worth

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 18 - 1859

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1

day, _____ hrs.

or _____ min.

7287

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

ll

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Andrew Worth

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Wloyd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

14.

INFORMANT

(Address)

Mrs Jim WorthBoyard Mo.

15.

FILED

11/271930Janie Henderson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Nov. 25 1930

17.

I HEREBY CERTIFY, That I attended deceased from

Nov. 25 1930that I last saw him alive on Nov. 25 1930, and that death occurred, on the date stated above, at Boyard Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Pancreas46F(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) 49 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAICTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Physical findings
W. M. Woodin M. D.11/27 1930 (Address) Boyard Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

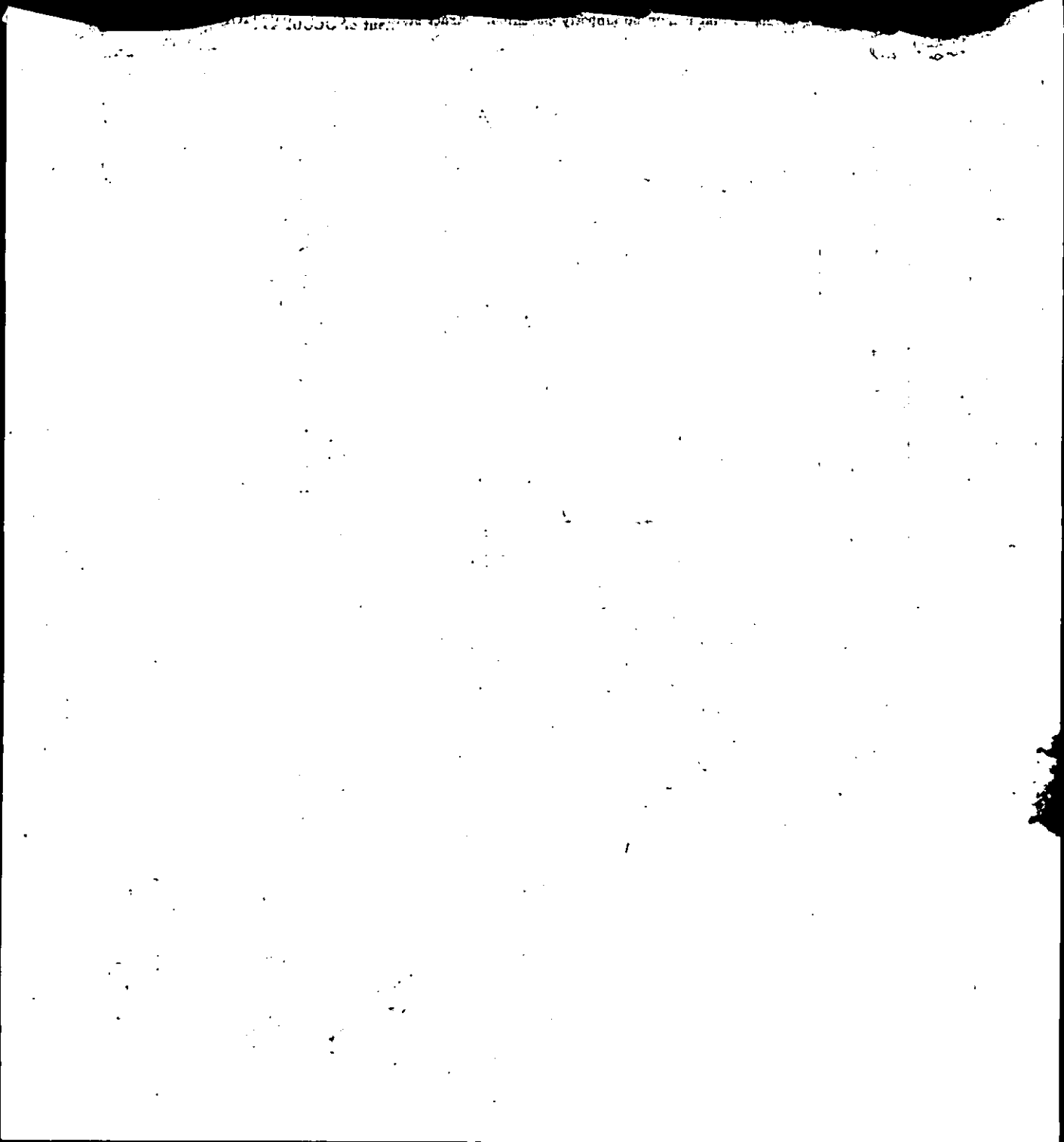
19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

mt Zion11/27 1930E. A. Decker Boyard Mo



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll

Registration District No. 133

File No.

Township

Primary Registration District No. 4074

Registered No. 22

City Boyard

(No.)

St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)

m

5A. If MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Mar 18-1859

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

71

8

7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED 11-27-1930

Janie Henderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 1930

17.

I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on 19....., and that
death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully scrutinized. AG. could be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms. First statement of OCCUPATION is very important.
REGISTRAR. ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-35550