

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

Do not use this space.

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis Mo.** (No. **2623**) **Lafayette Ave.** St. **23** Ward **23** (If nonresident, give city or town and State)
 Registered No. **29544** **8568**

2. FULL NAME **Fred William Worth**

(a) Residence. No. **2623 Lafayette** St., **23** Ward. (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 (<i>write the word</i>) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED - HUSBAND OF (OR WIFE OF) Vallie Worth				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 6, 1896				
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	34	7	29	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Butcher (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) **Iron County**
 (STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **Fred Worth**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Switzerland**
 12. MAIDEN NAME OF MOTHER **Susan Sapaux**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Reynolds Co. Missouri**

14. INFORMANT **Mrs. Vallie Worth**
 (Address) **2623 Lafayette**
 15. FILED **46-8-15** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-5-31** 19**31**
 17. I HEREBY CERTIFY, That I attended deceased from **Aug 10**, 19**31**, to **Aug 5**, 19**31** that I last saw him alive on **Aug 5**, 19**31**, and that death occurred, on the date stated above, at **9:45** p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Carcinoma Rectum
46D 466D
 (duration) **2** yrs. **6** mos. **0** ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH **St. Louis Mo**
 DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **8/10-1929**
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS **observation at operation**
 (Signed) **R. E. Owen**, M. D.
877.1931 (Address) **imperial Club Bldg**

*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 **Memorial Park Cemetery** DATE OF BURIAL **8-8-1931**
 ADDRESS **1631 No.**
 20. UNDERTAKER **W. McLaughlin**

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

