

FILED APR 21 1941  
Registration District No. 400

Primary Registration District No. 5532

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Little Blue  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson County Emergency  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community 26 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Grandview  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2  
year 1941 hour 6:45 am minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Feb.  
4, 1941 to March 2, 1941  
that I last saw her alive on March 1, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Bronchopneumonia - terminal

Due to fracture of left femur!

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence 04/2  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. O. Kennedy (M. D. or other) M.D.  
Address Jackson County Hospital Date signed 3/2/41

3. (a) PRINT FULL NAME Worthington Viola

8. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced W 3

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 25, 1869  
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Gowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name J. M. Skarkany

13. Birthplace Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Hains

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Jackson Co. Emergency

(b) Address Little Blue - Mo.

17. (a) Bellvue Mo. (b) Date thereof Mar 3, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellvue, Mo.

18. (a) Signature of funeral director E. F. George & Son

(b) Address Grandview, Mo.

19. (a) 3-5-41 (b) L. A. G. ...  
(Date received local registry) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

1954  
59

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *A. K. George*.....  
Licensed Embalmer No. *3645*.....  
P. O. Address..... *Grandview 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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10920  
Registrar's No. 49

Registration District No. 400

Primary Registration District No. 5533

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Prairie Tip  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Viola Wozzham

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 10 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration \_\_\_\_\_  
terminal  
Due to fract of left femur  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Includes pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 2-3-41

(c) Where did injury occur? Franklin, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature J. O. Kennedy (M. D. or other)

Address Jackson Co Hosp Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1941  
S-10920