

FILED MAR 20 1942

Registration District No. 260

Primary Registration District No. 5362

Registrar's No.

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town STEWARTSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Colfax Hosp
(If not in hospital or institution, write street number or location) V
(d) Length of stay: In hospital or institution. (Specify whether)
In this community forty five years
years, months or days)

3. (a) PRINT FULL NAME William Henry Worden

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married divorced married
6. (b) Name of husband or wife Emmaline Worden 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased Sept 24 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 5 17 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name Perry Worden
13. Birthplace Wisconsin
(City, town, or county) (State or foreign country)
14. Maiden name not known
15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant William Worden
(b) Address Stewartsville

17. (a) Burial (b) Date thereof 3-13-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stewartsville Mo

18. (a) Signature of funeral director F. J. Lyon

(b) Address Stewartsville Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb 32
(c) City or town Stewartsville
(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.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1942 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 22
1942 to March 11 1942

that I last saw him alive on March 11 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Erysipelas
Duration March 9-42

Due to Cause of skin of face 1941

Due to

Other conditions (Include pregnancy within 5 months of death)

Major findings: 53
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)
(b) Date of occurrence
(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?

While at work? (Specify type of place) (e) Means of injury ?

23. Signature J. M. Custer (M., D. or other) DO.
Address Stewartsville Mo. Date signed 3/12/42

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

MOTHER FATHER

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 *Danell D. Lyon*.....

Licensed Embalmer No. *3640*.....

P. O. Address *Plattsburg, N.Y.*.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6499
Registrar's No.

Registration District No. 260

Primary Registration District No. 5362

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Stewardsville
(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)

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 _____

3. (a) PRINT FULL NAME William H. Worden
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Duration _____
Due to _____
Due to _____

7. Birth date of deceased: Sept 24 (Month) (Day) (Year)
8. AGE: Years 87 Months 5 Days _____ (if less than one day) _____ min.

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-13-10 (b) CM Dugley
(Date received local registrar) (Registrar's signature)

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) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

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

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

