

S. No. 2  
4-1-41  
5-17-30  
PI X26390

31711

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

SEP 25 1943

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 751

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

1. PLACE OF DEATH:

(a) County: **GREENE**  
**Springfield**

(b) City or town: **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Johns Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: \_\_\_\_\_  
(Specify whether years, months or days)

In this community: \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Greene 039**

(c) City or town: **Springfield**  
(If outside city or town limits, write "RURAL")

(d) Street No.: **609 West Chestnut**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: **Harold Eugene Worthy**

3. (b) If veteran, name war: **None** 3. (c) Social Security No.: **None**

4. Sex: **Male 0** 5. Color of race: **White** 6. (a) Single, widowed, married, divorced: **Single 0**

6. (b) Name of husband or wife: **Infant** 6. (c) Age of husband or wife if alive: **XX** years

7. Birth date of deceased: **January 24 1943**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **September II**  
year: **1943** hour: **6:15** minute: \_\_\_\_\_ p. M.

21. I hereby certify that I attended the deceased from **9-7** 19**43** to **9-11** 19**43**  
that I last saw him alive on **9-11** 19**43**  
and that death occurred on the date and hour stated above.

8. AGE: Years: **0** Months: **7** Days: **19** If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: **Springfield Missouri 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **Infant**

Immediate cause of death: **Acute intestinal intoxication 6d**

Duration: \_\_\_\_\_

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: **Biventricular pneumonia 3d**  
(Include pregnancy within 3 months of death)

MOTHER FATHER {

11. Industry or business: **Infant**

12. Name: **Allen Wotthy**

13. Birthplace: **Miller Co. Missouri 0**  
(City, town, or county) (State or foreign country)

14. Maiden name: **Lena Tinsley**

15. Birthplace: **Republic Missouri 0**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **Allen Worthy**  
**Springfield Missouri**

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

17. (a) **Burial** (b) Date thereof: **Sept 13 43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Hazelwood Cemetery**

18. (a) Signature of funeral director: **J. W. Klingner & Co.**  
**Springfield Missouri**

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

19. (a) **9-13-43** (b) **Dr. M. Stanley**  
(Date received local registrar) (Registrar's signature)

PHYSICIAN

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

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

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: **Dr. M. Stanley** (M. D. or other): \_\_\_\_\_  
Address: **Springfield Mo** Date signed: **9-13-43**

786

(Licensed Embalmer's Statement on Reverse Side)

W

**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

*Max Rhodes*

Licensed Embalmer No.

4071

P. O. Address

*Springfield*

**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.**