

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Belle
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: At home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm. Fredric Worman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married Married
(b) Name of husband or wife Martha Adeline
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Jan 24 1869
(Month) (Day) (Year)

8. AGE: Year 75 Months 8 Days 7
If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Walter Worman

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

14. Maiden name Martha Adeline

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

16. (a) Informant Mr Wm. Worman

(b) Address Belle Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-44 (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Wm. Worman

(b) Address 1144 W 11th St

19. (a) 9/18/44 (Date received local registrar) (b) Erna Bennett (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1 year 1944 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from 9/1, 1944 to 9-11, 1944
that I last saw him alive on 9/1-44, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cornary Block

Due to _____

Due to _____

Other conditions Prostatic Trouble
(Include pregnancy within 3 months of death)

Major findings: 940

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) no

(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? no

While at work _____ (Specify type of place)

(e) Means of injury _____

Signature Dr. Jones (M. D. or other)

Address Belle Mo Date signed 9/3/44

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

10-4-44

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

Victor Brescher

Licensed Embalmer No.

3701

P. O. Address

Jefferson City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.