

Registration District No. **100**

Primary Registration District No. **1002**

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2813 Terrace  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 6 yrs years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson **48**  
(c) City or town 2813 Terrace Kansas City **3**  
(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 \_\_\_\_\_ **0**

**3. (a) PRINT FULL NAME** David J. Worth  
3. (b) If veteran, name war no 3. (c) Social Security No. no

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Oct day 26  
year 1944 hour 9 minute 30 A. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

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

7. Birth date of deceased July 14 1865  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
79 3 12 hr. min.

Immediate cause of death  
Arteriosclerotic heart disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Laborer

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Regular & history

**MOTHER FATHER**  
11. Industry or business \_\_\_\_\_  
12. Name John Worth  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name No Record  
15. Birthplace No record  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(c) 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?  
(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant John C. Worth  
(b) Address 2443 Jarboe  
17. (a) Burial (b) Date thereof 10 28 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill  
18. (a) Signature of funeral director Mrs. C.L. FORSTER  
(b) Address 918 Brooklyn  
19. (a) 10-27-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature C. L. Forster **3** (M. or F.)  
Address \_\_\_\_\_ Date signed 10/26/44

Duration  
Physician  
Underline the cause to which death should be charged statistically.

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

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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 \_\_\_\_\_

Licensed Embalmer No. 3599

P. O. Address H. C. 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, fact should be so stated above.**