

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
DEACONESS HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 DAYS  
(Specify whether years, months or days) 38 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS  
(c) City or town WEBSTER GROVES  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7817 GROVE AVE.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ADA MARSH WORTHINGTON

3. (b) If veteran, name war N.O. 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

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

7. Birth date of deceased JULY - 15 - 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 6 3 - hr. - min.

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

10. Usual occupation AT HOME

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

12. Name CARROLL MARSH

13. Birthplace BEAVER DAM WISCONSIN  
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET E. BROWNING

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

16. (a) Informant Ada Marsh Worthington

(b) Address 7817 Grove Shrubbery MO

17. (a) Burial (b) Date thereof Jan 20 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Parker, Under Co.

(b) Address Webster Groves Mo.

19. (a) JAN 20 1945 (Date received local registrar) J. F. Prebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18th year 1945 hour 5 minute 11 A.M.

21. I hereby certify that I attended the deceased from Jan 17 1945 to Jan 18 1945 that I last saw her alive on Jan 18 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cerebral Hemorrhage Duration 9 days

Due to arteriosclerosis

Due to 83

Other conditions Foster Radio & Alky  
(Include pregnancy within 3 months of death) AT

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) Accident

(b) Date of occurrence Jan 1, 1945

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 135

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Specify type of injury) Slipped

23. Signature Carl C Irick (M.D. or other)

Address Webster Groves Mo. Date signed 1-19-45

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

17  
9

96  
7  
NR 4

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

.....*Leslie Haleh*....., Registered Apprentice No. *362*  
working under my personal supervision.

Signed.....*E. C. Aldrich*.....

Licensed Embalmer No. *1332*

P. O. Address *Webster Groves M*

**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.**