

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

No. 2  
2-43  
17-39  
X33697

FILED APR 14 1947

318

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11728

3245

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4949 Fontaine Blvd  
(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 Mo (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4949 Fontaine Blvd  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Susan Worley

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

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Feb 10 1871  
(Month) (Day) (Year)

8. AGE: Years about 76 Months — Days — If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name Louder Worley

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

14. Maiden name Susan Worley

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

16. (a) Informant Lera Kerr

(b) Address 4949 Fontaine Blvd

17. (a) Burial (b) Date thereof 3/31/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Ph

18. (a) Signature of funeral director Frank Toney

(b) Address 9189

19. MAR 27 1947 (b) J. F. Breck  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25  
year 1947 hour 3 minute 45 P.M.

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.

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

Cerebral apoplexy  
Due to \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 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) (or Means of injury)

23. Signature John E. ... (of physician)

Address \_\_\_\_\_ Date signed 3/25

**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 *Clark Young*

Licensed Embalmer No. *33710*

P. O. Address *St. Louis*

**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.**

Registration District No. 314

Primary Registration District No. 1003

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:  
.....  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Susan Worley

3. (b) If veteran,  
name war.....

3. (c) Social Security  
No.....

4. Sex 7

5. Color or  
race B

6. (a) Single, widowed, married,  
divorced Widow

6. (b) Name of husband or wife Mark

6. (c) Age of husband or wife if  
alive.....

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Day (if less than one day)  
at 96 .. hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

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

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April  
year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

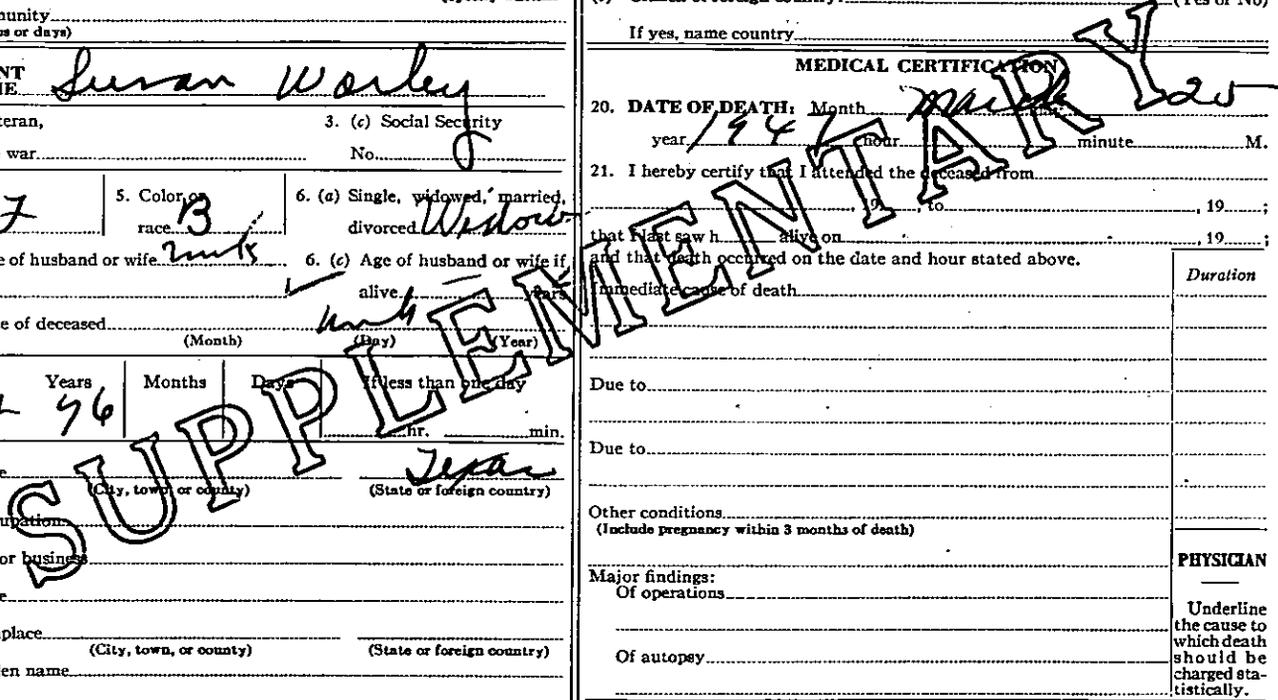
22. If death was due to external causes, fill in the following:

(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..... (M. D. or other)  
Address..... Date signed.....

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



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