

National Office of Vital Statistics  
FILED FEB 3 1948

Registration District No. 277

Primary Registration District No. 5-949

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Cypress - Rural  
(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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pike

(c) City or town CYRESS - RURAL  
(If outside city or town limits, write "RURAL")

(d) Street No. RR  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNIE GLADYS WORSHAM

3. (b) If veteran \_\_\_\_\_ name war X

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18  
year 1948 hour 7 minute P M.

21. I hereby certify that I attended the deceased from 1-3-48  
\_\_\_\_\_, 19\_\_\_\_, to 1-7-48, 19\_\_\_\_

that I last saw her alive on 1-15, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Duration 3 Months

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced 2

(b) Name of husband or wife George Worsham 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Sept 14 1864  
(Month) (Day) (Year)

Immediate cause of death Myocardial Infarction

Due to yes

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

Other conditions (within 3 months of death) 1-2-48

8. AGE: Years 82 Months 4 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Mountjoy Browning

12. Name \_\_\_\_\_

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

14. Maiden name Elizabeth

15. Birthplace Pike Co Mo  
(City, town or county) (State or foreign country)

16. (a) Informant Mrs. Alfred Robinson

(b) Address Cypress Mo

17. (a) Burial (b) Date thereof 1-20-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Mo

18. (a) Signature of funeral director Walter B. Mansfield

(b) Address Bowling Green Mo

19. (a) 1-24-48 (b) Bill Robinson  
(Date received local registrar) (Registrar's signature)

Major findings: Fracture Hip

Of operations \_\_\_\_\_

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

PHYSICIAN 1-2-48

Underline the name of the physician which 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? \_\_\_\_\_  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Walter B. Mansfield (M. D. or other) MD

Address Bowling Green Mo Date signed 1-20-48

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

2025

RECEIVED

District Health Officer No. 10

District File Number 1-48-190

Date Filed JAN 30 1948

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 \_\_\_\_\_

*Harold C. Kline*

Registered Apprentice No. *4*

working under my personal supervision.

Signed

*Grace M. Donahue*

Licensed Embalmer No. *2214*

P. O. Address

*Bowling Green, 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.

Registration District No. 277 Primary Registration District No. 5949

1. PLACE OF DEATH:

(a) County Pike  
(b) City or town Rural  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Annie G. Worskan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 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 Sept 14 (Month) (Day) (Year)

8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Data received local registrar)

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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1948 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I aut saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Fall at home  
Due to fractured hip  
Done 1-1-48  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_ 186 A  
118

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) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

8-2025