

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8715

State File No.

BIRTH NO. REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 114

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Liberty	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitarium		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Bert b. (Middle) H c. (Last) Haworth		4. DATE OF DEATH (Month) (Day) (Year) Mar. 30, 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Mar. 8, 1884
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (State or foreign country) Lincoln, Mo.
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME James A. Haworth	
14. MOTHER'S MAIDEN NAME Joanna Wachs		15. NAME OF HUSBAND OR WIFE Mary B. Haworth (deceased)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 496 07 3186	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma, generalized ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pathologist	
20. DATE OF OPERATION 1949		21. MAJOR FINDINGS OF OPERATION Pathologist	
22. ACCIDENT SUICIDE HOMICIDE (Specify)		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		25. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
26. HOW DID INJURY OCCUR?		27. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)	
28. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:05P m., from the causes and on the date stated above.			
29. SIGNATURE W. E. Upsher		30. ADDRESS MS 1, 2800 Main	
31. DATE SIGNED 3/31/49		32. DATE OF BURIAL, CREMATION, REMOVAL (Specify) burial	
33. DATE Apr. 2, 1949		34. NAME OF CEMETERY OR CREMATORY Mt. Washington	
35. LOCATION (City, town, or county) (State) Kansas City, Mo.		36. FUNERAL DIRECTOR'S SIGNATURE W. E. Upsher	
37. ADDRESS Independence, Mo.		38. DATE REC'D BY LOCAL REG. Apr. 1, 1949	
39. REGISTRAR'S SIGNATURE W. E. Upsher		40. (Licensed Embalmer's Statement on Reverse Side)	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Donald W. Hanks

Signed _____
Student Embalmer

Licensed Embalmer No. 4528

P. O. Address Independence, Missouri

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.