

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29505

FILED SEP 30 1949

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 5170 Registrar's No. 318

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|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CALLAWAY</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GUTHRIE R. P. Twp.</u> | | c. LENGTH OF STAY (in this place) <u>1 yr.</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GUTHRIE Round Prairie Twp.</u> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>GUTHRIE, MO.</u> | | | d. STREET ADDRESS (If rural, give location) <u>GUTHRIE, MO.</u> | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>NINA</u> | b. (Middle) <u>W</u> | c. (Last) <u>WORSHAM</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 16, 1949</u> |
|-------------------------------------|------------------------|----------------------|--------------------------|---|

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|-------------------|---------------------------|---|--|---|--|--------------------------------|
| 5. SEX <u>Fe.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>SEPT. 24, 1857</u> | 9. AGE (In years last birthday) <u>91</u> | IF UNDER 1 YEAR (Month) (Day) <u>11 22</u> | IF UNDER 24 HRS. (Hour) (Min.) |
|-------------------|---------------------------|---|--|---|--|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>*</u> | 11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>STEPHEN CONGER</u> | 13b. MOTHER'S MAIDEN NAME <u>LUCY GORDEN</u> | 14. NAME OF HUSBAND OR WIFE <u>JOHN J. WORSHAM (DEC.)</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>*</u> | 16. SOCIAL SECURITY NO. <u>*</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>MRS. JOHN McCARTY</u> | ADDRESS <u>GUTHRIE, MO.</u> |
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| 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. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Vascular Heart Disease</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <u>rise to the above cause (a) stating the underlying cause last.</u> DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | <u>4214</u> | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
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22. I hereby certify that I attended the deceased from Sept 1, 1949, to Sept 16, 1949, that I last saw the deceased alive on Sept 3, 1949, and that death occurred at 6 a. m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>E. M. Runk M.D.</u> | 23b. ADDRESS <u>New Bloomfield Mo</u> | 23c. DATE SIGNED <u>Sept 17 49</u> |
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|---|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Sept 17-1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Carrington Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Carrington Mo</u> |
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| DATE REC'D BY LOCAL REG. <u>Sept 17 1949</u> | REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> | 4026 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Hallace Funeral Home</u> | ADDRESS <u>Tulton Mo</u> |
|--|---|------|--|--------------------------|

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

1406

District File Number _____
District Health Officer No. 9,
RECEIVED
SEP 27 1949

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.

Student
Student Embalmer

Signed Denzil C. Browning

Licensed Embalmer No. 2727

P. O. Address Fuller 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.