

FILED MAY 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17889

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles</u>		c. LENGTH OF STAY (In this place) <u>61 yrs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1038 South Main St</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles</u>	
		d. STREET ADDRESS (If rural, give location) <u>702 South Main St</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>OPAL</u> b. (Middle) <u>V</u> c. (Last) <u>WORFUL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 3 1950</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 24 1888</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St Charles County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Richard Seeberger</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Fisher</u>		14. NAME OF HUSBAND OR WIFE <u>Ben Worful</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Elroy Feldman</u> ADDRESS <u>1038 So. Main</u>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Carcinoma of Bones</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 0 d</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of sigmoid</u>		?	
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>153X</u>	

19a. DATE OF OPERATION <u>Apr 2-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Sigmoid - Colostomy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 7 1950 to May 3 1950, that I last saw the deceased alive on May 2 1950, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>J M [Signature]</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>St Charles Mo</u>			23c. DATE SIGNED <u>5-3-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 5 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Charles Mo</u>		
DATE REC'D BY LOCAL REG. <u>5/10/50</u>		REGISTRAR'S SIGNATURE <u>Thanna Hamilton</u> <u>594</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hackmann</u> ADDRESS <u>St Charles Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 48

*Jensen*

District File Number -----

District Health Officer No. 9,

MAY 15 1956

RECEIVED

MAR 6 1957

**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 *Arthur C. Bauer*

Licensed Embalmer No. 3145

P. O. Address *St. Charles 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.