

FILED AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Wilson 21414

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>297</u>	
1. PLACE OF DEATH a. COUNTY <u>CAPE Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>CAPE GIRARDEAU</u>		c. LENGTH OF STAY (in this place) <u>6 DAYS</u>		c. CITY OR TOWN <u>RURAL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>S.E.M.O. HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>COMMERCE RD #1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) <u>KATE</u>		c. (Last) <u>WORLEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-30-1955</u>	
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>MAR. 1896</u>		9. AGE (In years last birthday) <u>59</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MALINO TENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>R. L. MARSHALL</u>		13b. MOTHER'S MAIDEN NAME <u>ISABELLA COUCH</u>		14. NAME OF HUSBAND OR WIFE <u>M. C. WORLEY JR.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>McWorley Sr - Commerce Mo 2701</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>Cerebral vascular accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>331X</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) (Min) _____		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 <u>7-25-</u> 19 <u>55</u> , to <u>7-30-</u> 19 <u>55</u> , that I last saw the deceased alive on <u>7-30-</u> 19 <u>55</u> , and that death occurred at <u>4:30 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Charles F. Wilson M.D.</u> (Degree or title)		23b. ADDRESS <u>717 Broadway Cape Girardeau Mo</u>		23c. DATE SIGNED <u>8-7-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8-2-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>			
DATE REC'D BY LOCAL REG. <u>8-3-55</u>		REGISTRAR'S SIGNATURE <u>C. P. Summers</u> <u>44-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Weld Funeral Home - Sikeston Mo</u>			

(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..

Student.....
Signature of Student Embalmer

Signed..... *Raymond Crews*

Licensed Embalmer No. *346*

P. O. Address *Stanton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.