

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25863

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 236

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farmington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Farmington</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Easter Nursing Home</u>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vonda</u> Middle <u>G.</u> Last <u>Worst</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1883</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Sandusky, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Wesley Worst</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Long</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Thayne McDonald, Chicago, Ill.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Thrombotic Encephalomalacia</u>					<u>Ad</u>
DUE TO (c) <u>Arteriosclerosis (First seen)</u>					<u>1956</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bilateral stasis ulcers lower legs</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>7-11-57</u> to <u>7-20-57</u> and last saw her alive on <u>7-20-57</u> Death occurred at <u>4:50 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Garold E. Enbe 2D</u>			22b. ADDRESS <u>175 Jackson St.</u>		22c. DATE SIGNED <u>7-23-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 23, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Freemont, Ohio</u>
24. FUNERAL DIRECTOR ADDRESS <u>Cozean Funeral Home, Farmington, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>July 23, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

1 AUG 2 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
Signature of Student Embalmer

Signed
C. H. Cozear

Licensed Embalmer No.

P. O. Address
Farming

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING 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.