

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
518

1003

STATE FILE NUMBER

34339  
8388

Registration District No.

Primary Registration District No.

Registrar's No.

300  
1-57

|   |                           |  |   |  |  |
|---|---------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Arkansas<br>b. COUNTY<br>Craighead |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br>ST. LOUIS, MISSOURI            |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN<br>Black Oak, Arkansas  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| 4<br>c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION<br>BARNES HOSPITAL |                           | Length of stay in lb<br>33   | STREET<br>ADDRESS<br>City   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>DON, DORA WORLDS                           |                           |  | 4. DATE OF DEATH<br>Month Day Year<br>SEPTEMBER 3, 1957   |  |  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>July 8, 1883  |  | 9. AGE (In years last birthday)<br>74                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br>Arkansas                                       |  |
| 10c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                           | 13a. FATHER'S NAME<br>Unknown  |   | 13b. MOTHER'S MAIDEN NAME<br>Unknown   |  |
| 13c. NAME OF HUSBAND OR WIFE<br>Bob Worlds (Husband)  |                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |   | 16. SOCIAL SECURITY NO.<br>None  |  |
| 17. INFORMANT<br>Mr Bob Worlds; Black Oak Arkansas  |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>4200 |   | INTERVAL BETWEEN ONSET AND DEATH<br>YRS.   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour Month, Day, Year<br>a.m. p.m.   |                           | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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<br>COUNTY STATE  |                           | 21. I attended the deceased from NOV. 1, 1939 to SEPT. 3, 1957 and last saw her alive on SEPT. 3, 1957<br>Death occurred at 3:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.   |   | 22a. SIGNATURE<br>(Degree or title)<br>C. P. Vermillion, M.D.                                |  |
| 22b. ADDRESS<br>BARNES HOSPITAL   |                           | 22c. DATE SIGNED<br>9/3/57   |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |  |
| 23b. DATE<br>9/5/57   |                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Goss Cemetery  |   | 23d. LOCATION (City, town, or county) (State)<br>Monette, Arkansas                           |  |
| 24. FUNERAL DIRECTOR<br>Gregg Funeral Home- Monette, Arkansas   |                           | 25. DATE RECD. BY LOCAL REG.<br>SEP 7 57   |   | 26. REGISTRAR'S SIGNATURE<br>J Carl Smith M.D.<br>LHKS                                       |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Joseph E. McCulloch* .....

Licensed Embalmer No. *2460*

P. O. Address *6175 Dolman*

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.