

THE DEPARTMENT OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

38873

FILED NOV 4 1957

STATE FILE NUMBER

Registration District No. **337** Primary Registration District No. **6195** Registrar's No. **78**

V. S. 300  
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Shelby</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SALT RIVER TWSP</b>		c. CITY OR TOWN <b>SALT RIVER TOWNSHIP</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3 mi NE of SHELBYNA</b>		d. STREET ADDRESS (If outside, give location) <b>3 MILES N.E. OF SHELBYNA</b>	
Length of stay in lb <b>26 MONTHS</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Grover</b> Middle <b>(None)</b> Last <b>Worthen</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>30,</b> Year <b>1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 26, 1891</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	11. BIRTHPLACE (City and state or country) <b>JACKSON COUNTY, ILL.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>ANDREW WORTHEN</b>	13b. MOTHER'S MAIDEN NAME <b>LUCINDA FRALEY</b>	14. NAME OF HUSBAND OR WIFE <b>MATTIE MEZO WORTHEN</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	16. SOCIAL SECURITY NO. <b>359-12-3560</b>	17. INFORMANT <b>ANDREW WORTHEN,</b> Address <b>SHELBYNA, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured abdominal aortic aneurysm</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>451XH</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Carcinoma of stomach</b>		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.) <b>451XH</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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.) <b>451XH</b>	20f. CITY, TOWN, OR LOCATION <b>451XH</b>	COUNTY _____ STATE _____
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21. I attended the deceased from <b>June 1957</b> to <b>Oct 30, 1957</b> and last saw <sup>him</sup> alive on <b>Oct 30, 1957</b> Death occurred at <b>6:25 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Chas. A. Lichty, MD</b> (Degree or title)	22b. ADDRESS <b>Shelbyna, Mo.</b>	22c. DATE SIGNED <b>10/31/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11/21/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WORTHEN CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>MURPHYS BORO, ILLINOIS</b>
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24. FUNERAL DIRECTOR <b>HAYES FUNERAL HOME</b> ADDRESS <b>SHELBYNA, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Oct 30-1957</b>	26. REGISTRAR'S SIGNATURE <b>Ada Garrison</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

19-0

NOV 21 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 *Paul E. Hayes* .....

Licensed Embalmer No. *4461*

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