

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30910

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Rau Primary Registration District No. 1347
City Rauville City (No. 7116 Penn)

File No. _____
Registered No. 3434
St. _____ Ward _____

2. FULL NAME Stephen Jasper Worley

(a) Residence No. 7116 Penn St. 8 Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 6 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male | **4. COLOR OR RACE** white | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 18 1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR WIFE OF Mary Matilda Turner

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 17, 1929, that I last saw him alive on Sept 17, 1929, and that death occurred, on the date stated above, at 3 a m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
85 | | |

Paralysis PVA
87D
(duration) yrs. mos. da.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Johanna Co. (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH... place of death

10. NAME OF FATHER John Worley

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee (STATE OR COUNTRY)

WAS THERE AN AUTOPSY? No.

12. MAIDEN NAME OF MOTHER Mary Malissa Scagg

WHAT TEST CONFIRMED DIAGNOSIS?

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown (STATE OR COUNTRY)

(Signed) J. W. Ferrel, M. D.
9/18, 1929 (Address) 500-H 74

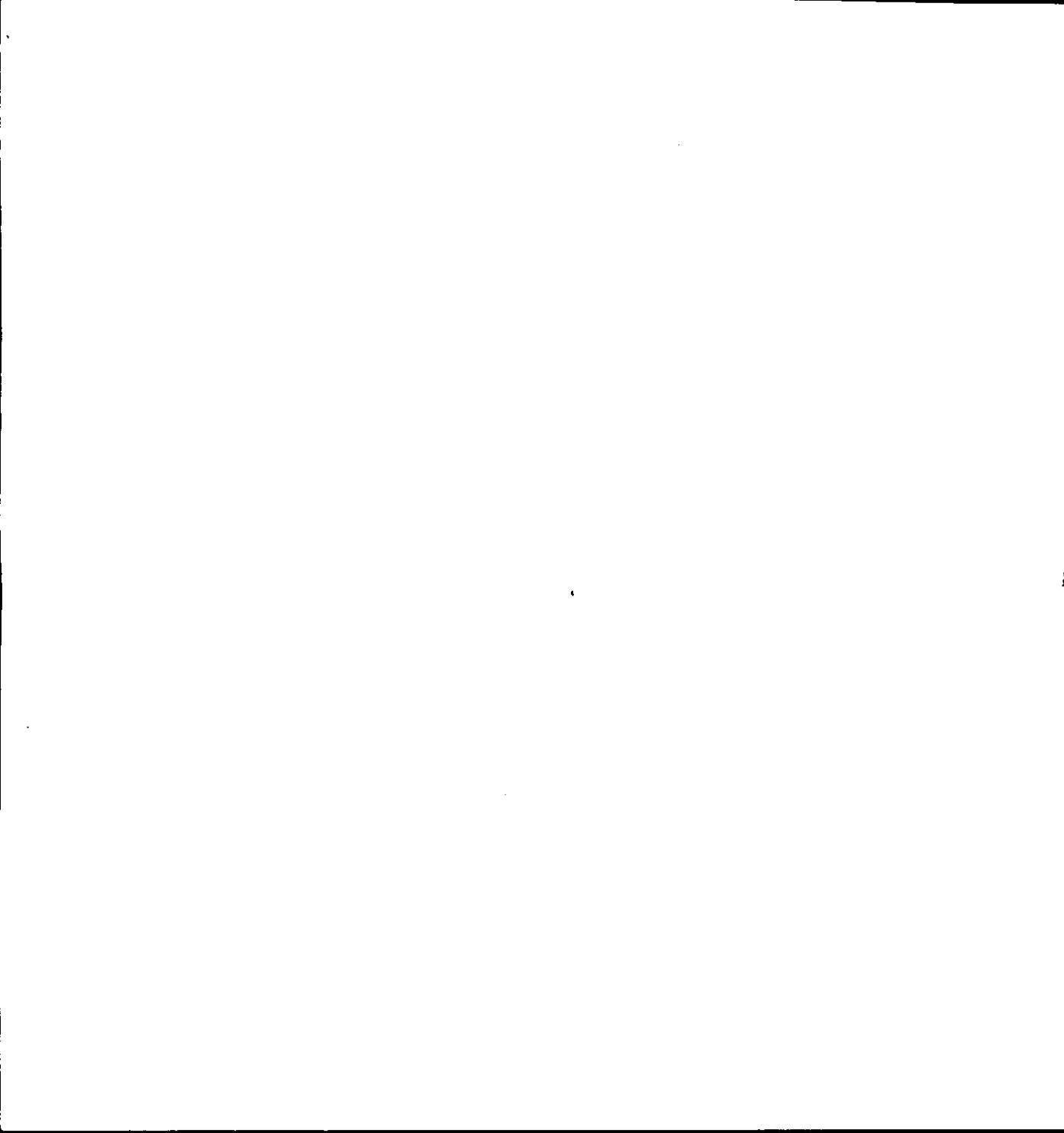
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Mrs. A. Huckworth (Address) 7116 Penn.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Adena cemetery **DATE OF BURIAL** 9-18-1929

15. FILED 9/18, 1929 M.M. Croove REGISTRAR

20. UNDERTAKER Blincov & Sons **ADDRESS** Adena Mo.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 3934
 City City (No.) St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 9/18 1929 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1929

17. I HEREBY CERTIFY that I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Autolysis
Coronary Hemorrhage
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) MI
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. J. Deane, M. D.

, 19 (Address) 410 W 75

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30910