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

Do not use this space.

23555

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township Marion — Primary Registration District No. 3079 — Registered No. 169

City Hannibal (No. 802 S. Hayden St. 6th Ward)

2. FULL NAME Thomas Jefferson Worden

(a) Residence. No. 802 S. Hayden St., 6th Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 12

7. AGE: YEARS 69 — MONTHS 11 — DAYS 19 — IF LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): "
(c) Name of employer: Himself

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): New York

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT: Sarah Warden
(Address) Hannibal, Mo.

15. FILED 12, 1930 C. Cousens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 1 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to July 1st, 1930 that I last saw him alive on July 1, 1930, and that death occurred, on the date stated above, at 2:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute appendicitis
121 B

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) 117 B

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) R. Hearnridge, M. D.

July 2, 1931 (Address) Hannibal Mo

*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: Mt. Olivet Cemetery — DATE OF BURIAL: July 3 1930

20. UNDERTAKER: Roy P. Schwartz — ADDRESS: Hannibal, Mo.

N. B.—Every ... supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 26 1930

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 Marion — Registration District No. 547 — File No. .....

Township ..... — Primary Registration District No. 3029 — Registered No. 169

City Hannibal (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Jefferson Worden

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12th 1860

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
69	11	19	

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)

PARENTS
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 7/2, 1930 C E Clausius
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1 1930

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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) ....., M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully [illegible] AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain [illegible] classified. Exact statement of OCCUPATION is very important.

REGISTRARS [illegible] CATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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