

FILED APR 1 1940

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

111018

Do not use this space.

## 1. PLACE OF DEATH

(a) County Greene Registration District No. 317  
 (b) Township Brookline Primary Registration District No. 5441  
 (c) City or (d) Street No. \_\_\_\_\_ St.  
 (e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number) yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

ALICE EVA WORMER  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Jacob Wormer</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 19-1852</u>		
7. AGE	YEARS <u>82</u>	MONTHS <u>10</u>
	DAYS <u>27</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>None</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year) <u>3/10-1940</u>	11. Total time (years) spent in this occupation <u>60</u>
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Anassa Iowa</u>	
	13. NAME <u>Martin Wheaton</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>	
	15. MAIDEN NAME <u>Elizabeth Potter</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New Jersey</u>	
17. INFORMANT (ADDRESS) <u>O. E. Baker Brookline Mo. Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Brookline Mo.</u> DATE <u>Mar 19 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>R. E. Thurman &amp; Co. Republic Mo.</u>		
20. FILED <u>Mar 19 1940 Mrs Bertha Nance Local Registrar.</u>		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March-17 194022. I HEREBY CERTIFY, That I attended deceased from March 10 1940, to March 17 1940I last saw her alive on March 17 1940 Death is saidto have occurred on the date stated above, at 5:10 P. m.

The principal cause of death and related causes of importance were as follows:

Cerebral HemorrhageDate of onset  
3/10-40Other contributory causes of importance: 82 yrName of operation none Date of \_\_\_\_\_What test confirmed diagnosis? Clinical Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) E. M. LeCompte, M. D.(Address) Brookline Mo. Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully 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.

MARGIN RESERVED FOR BINDING

80M-9-19-38  
V. S. NO. 2.

I X18608

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11018

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 317

Primary Registration District No. 3441

Registrar's No. \_\_\_\_\_

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Brookline Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days)

3. (a) PRINT FULL NAME Alice Eva Warner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased apr 19 1858  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>10</u>	<u>27</u>	hr. min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Mar. 19 (b) Mrs. Bertha Nance  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene  
(c) City or town Brookline Sta  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature T. M. LeCompte (M.D. or other) \_\_\_\_\_  
Address Brookline Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940  
S-11018