

197
Registration District No. **197**

Primary Registration District No. **5276**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town rural Gallatin *Mojo*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
North Kansas City, route #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 10 years
(years, months or days)

3. (a) PRINT FULL NAME Rufus Worrell

3. (b) If veteran, name war no

3. (c) Social Security No. 493-12-0783

4. Sex male 5. Color or race white

6. (a) Single, widowed, divorced, married

6. (b) Name of husband or wife Amanda R. Worrell

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Nov. 27, 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>9</u>	<u>15</u>	hr. _____ min. _____

9. Birthplace Ray County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation W.P.A. & formerly mgr

11. Industry or business label dept. Ridnour-Baker

MOTHER FATHER { 12. Name Thomas Worrell

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

14. Maiden name Elizabeth Albright

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

16. (a) Informant Mrs. Amanda R. Worrell

(b) Address Rt 4 North Kansas City, Mo.

17. (a) Burial (b) Date thereof Sep 14, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem. Lawson, Mo.

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North K. C. Mo.

19. (a) 9/12/40 (b) John S. Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

(c) City or town North Kansas City (rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Route #4
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1940 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from Sept 20, 1940, to Sept 12, 1940
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to _____ 54

Other conditions Diabetes
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) no

(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?
963

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

23. Signature Samuel J. Hodge (M. D. or other) 1

Address North Kansas City Mo Date signed 9-12-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-11-40

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.....

Harold L. Posson

Registered Apprentice No.

working under my personal supervision.

Signed Harold L. Posson

Licensed Embalmer No. 3605

P. O. Address North K. C. 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3175-7**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **197**

Primary Registration District No. **5276**

Registrar's No.

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

1. PLACE OF DEATH

(a) County **Christian**
(b) City or town **Ballwin**
(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.....
years, months or days)

3. (a) PRINT FULL NAME

Rufus Warrell

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 9 15 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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..... (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) **9/12/40** (b) **John S. Horton**
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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 **Sept** day **17**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... 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) (r) Means of injury.....

23. Signature **Russell L. Hoge** (Name of other)

Address **77 K.C.** Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

