

Registration District No. **419** Primary Registration District No. **0373**

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Rural - McDonald  
(c) Name of hospital or institution:  
Route # 1, Reeds, Mo.  
(d) Length of stay: In hospital or institution 3  
In this community 3 Months.

3. (a) PRINT FULL NAME Mary Worman  
(b) If veteran, name war None (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
7. Birth date of deceased April 19, 1860

8. AGE: Years 80 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Augusta, Ill

10. Usual occupation Housewife

11. Industry or business  
12. Name Simon Weinberg  
13. Birthplace Germany  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant's own signature Mrs. Warren Campbell  
(b) Address Route # 1, Reeds, Mo.

17. (a) Removal (b) Date thereof 9-11-40  
(c) Place: burial or cremation Plymouth, Ill.

18. (a) Signature of funeral director Ulmer Funeral Home  
(b) Address 1208 Garrison Ave., Carthage, Mo.

19. (a) 9-11-1940 (b) Mrs. W. O. Hall.

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County \_\_\_\_\_  
(c) City or town Plymouth  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 10th,  
year 1940 hour 9:15 minute P. M.

21. I hereby certify that I attended the deceased from July 2, 1940 to Sept. 10, 1940  
that I last saw her alive on Sept. 10, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion  
Hypertension  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 37A  
While at work? \_\_\_\_\_ (Specify type of place)  
Mo. \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signatur Warren Campbell (M. D. or other) \_\_\_\_\_  
Address Carthage Mo. Date signed 9/10/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

40-10-427

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

Gene P. Dugh, Registered Apprentice No. 253  
working under my personal supervision.

Signed

Edlellmer

Licensed Embalmer No. 2222

P. O. Address. Carthage

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.