

V. S. No. 2  
FORM-5-42  
Rev. 5-17-39  
X32873

James Worley. 9722

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED APR 14 1943  
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 330

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph

(c) Name of hospital or institution:  
519 1/2 Mesquite St  
(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 (Specify whether)

3. (a) PRINT FULL NAME James Worley

3. (b) If veteran, name war no

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: Unknown

8. AGE	Years	Months	Days	If less than one day
abt 86	86			hr. _____ min.

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

10. Usual occupation unknown

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

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant No Record

(b) Address St Joseph, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-43 (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address 1946 Calhoun St St Joseph Mo

19. (a) 2-27-43 (Date received local registrar) (b) Rose Keyser (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 519 1/2 Mesquite St (If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 24th year 1943 hour 8 minute 306 M.

21. I hereby certify that I viewed the deceased from on Feb 24th 1943 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: Acute Congestive Heart Failure 1 day

Due to Chronic Myo-Carditis 4 yrs

Due to Chronic Bronchial Asthma 4 yrs

Other conditions: Man was found dead in his room following severe major findings: Of operations attacks of asthma and heart disease

Of autopsy NO

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 H F Mundy (M. D. or other) 3

Address 404 So 3d St Date signed 2/24/43

1283

(Licensed Embalmer's Statement on Reverse Side)

**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

working under my personal supervision.

Registered Apprentice No.

Signed

*Robert H. Geph*

Licensed Embalmer No.

3305

P. O. Address

*St. Joseph, 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.**