

S. No. 2
OM-2-43
5-17-39
X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43987**

FILED JAN 13 1944

Registration District No. **287**

Primary Registration District No. **4499**

Registrar's No. **111**

1. PLACE OF DEATH:

(a) County Shelby Co.
(b) City or town Shelbina, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 64 years (Specify whether
In this community 64 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby
(c) City or town Shelbina, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Kate F. Worland
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married. 2 divorced Widowed
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased July 23rd, 1959
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 4 12 hr. min.

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

10. Usual occupation House wife

11. Industry or business Same

MOTHER FATHER

12. Name Ben Gillaspie
13. Birthplace Monroe Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth C. Smith
15. Birthplace Monroe Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Roland Lasley

(b) Address Shelbina, Mo.

17. (a) Burial (b) Date thereof 12-7-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina, Mo.

18. (a) Signature of funeral director Mullin & Barkum
(b) Address Shelbina, Missouri

19. (a) Jan 8 43 (b) Madge Good
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 5
year 43 hour 11 minute P. M.
21. I hereby certify that I attended the deceased from 6-10-38
1938 to 12-4-43 1943
that I last saw her alive on 12-4-43 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arterio-sclerosis Duration 3 yrs.

Due to _____
Due to _____

Other conditions mental deterioration 4 yrs.
(Include pregnancy within 3 months of death)

Major findings:
Of operations 99
Of autopsy _____
PHYSICIAN
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? _____ (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 A. M. Wood (M. D. or other)
Address Shelbina, Mo. Date signed 12-30-43

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

RECEIVED

District Health Officer No. 10

District File Number 1-44-127

Date Filed JAN 12 1944

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 EW Hawkins

Licensed Embalmer No. 3498

P. O. Address Shelburne Vt

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.