

STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10227**

**FILED APR 1945**  
Registration District No. **1045**

Primary Registration District No. **1002**

Registrar's No. **1170**

**1. PLACE OF DEATH:**  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**K. C. General Hospital No. 10**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 month**  
(Specify whether  
In this community **2 years**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Robt. E. Lee Hotel**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Nell Worthing**  
**3. (b) If veteran,** **--** **3. (c) Social Security**  
name war. **--** No. **482-10-1483**

**4. Sex** **F** **5. Color or** **W**  
race **W**  
**6. (a) Single, widowed, married,** **6. (c) Age of husband or wife if**  
divorced **Married** alive **57** years  
**6. (b) Name of husband or wife** **Chas. D. Worthing**  
**7. Birth date of deceased.** **July 30, 1891**  
(Month) (Day) (Year)

**8. AGE:** Years **52** Months **7** Days **14**  
If less than one day  
hr. \_\_\_\_\_ min.

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

**10. Usual occupation** **Cashier**

**11. Industry or business** **Muehlebach Hotel**

MOTHER FATHER

**12. Name** **Wm. M. Hilfioker**

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

**14. Maiden name** **Unknown**

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

**16. (a) Informant** **Frank Worthing**

**(b) Address** **Lakewood Ohio**

**17. (a) Removal** **(b) Date thereof. Mar. 14-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Des Moines, Iowa**

**18. (a) Signature of funeral director** **Shell Funeral Home**

**(b) Address** **K.C. Mo. T. C. Brown**  
**3-14-44** **(b) (c) Registrar's signature**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **March** day **14**  
year **1944** hour **8** minute **30** A.M.

**21. I hereby certify that I attended the deceased from**  
**February 12, 1944 to March 14, 1944;**  
that I last saw her alive on **March 14, 1944;**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute generalized**  
**peritonitis due to intestinal**  
**obstruction**

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

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

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

Of autopsy **See above**

**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)  
(c) Means of injury \_\_\_\_\_  
**23. Signature** **A. E. Washer** **Med. Dir. M. H.**  
**23. McCoy** **3-14-44**  
Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

*122 fr*

**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. *3625*

P. O. Address *K. C. Va*

**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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1170

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution: General Hosp.  
(If not in hospital or institution, write street number and 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 Will Worthing

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

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

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..... 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) 5/15/44 (Date received local registrar) (b) T. E. Brown (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.

20. DATE OF DEATH: Month Mar day 14  
year..... 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: Acute, generalized peritonitis due to intestinal obstruction  
Due to.....  
Due to: Previous laparotomy for intestinal obstruction  
Other conditions..... (Include pregnancy within 5 months of death) resection

Major findings: of bowel.  
Of operations..... Cause unknown.  
Of autopsy..... 17762

PHYSICIAN  
Duration  
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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. E. Upsher (M. D. or other) RC mo  
Address..... Date signed.....

SUPPLEMENTARY

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

10227