

FILED MAY 31 1944

Primary Registration District No. **4012**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Atchison**  
 (b) City or town **Rack Port**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**County Home 3**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County **3**  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Isaac Morgan Worl**

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

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

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

7. Birth date of deceased: **May 21 1868**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **11** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name **Joseph Worl**  
 13. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Uple Mina Thompson**  
 15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Juan Mabrey**  
 (b) Address **Fairfax Mo**

17. (a) \_\_\_\_\_ (b) Date thereof **April 25 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **English Grace Cemetery**

18. (a) Signature of funeral director **Bojistrans Funeral Home**  
 (b) Address **Rack Port Mo**

19. (a) **April 23 1944** (b) **Mrs. Herbert Townsend**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22**  
 year **1944** hour **2 P.M.** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **April 19-1944** to **April -22-1944**, that I last saw him alive on **April -21-1944**, and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion** Duration  
**Arterio Sclerosis** **2 yrs.**

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

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

Other conditions **94a**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 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) (c) Means of injury

23. Signature **J. M. Davis** (M. D. or other) \_\_\_\_\_  
 Address **Clarkie SMC** Date signed **4-28-44**

1535

**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.....

*Frost A. Browning*

Licensed Embalmer No.....

*3338*

P. O. Address.....

*Ladles, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**- If this body is not embalmed, fact should be so stated above.**

Registration District No. 4 Primary Registration District No. 4012 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Atchison  
(b) City or town Rockport  
(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 Atchison Co. Home (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Atchison  
(c) City or town County Home  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Isaac M. Ward  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April Day 2  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w  
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 May 31  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her arrive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 79 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Shower.

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

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Miss Herbert Lawrence  
(Date received local registrar) (Registrar's signature)

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)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

B  
3  
6930

17290