

Registration District No. 743

Primary Registration District No. 5298

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Stewartsville, Rural Lafayette
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 17 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton
(c) City or town Stewartsville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ida Lola Worth.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Thornton Worth 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased March 24 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 1 16 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name W.H. Suffield
13. Birthplace Ill. (City, town, or county) (State or foreign country)
14. Maiden name Anna Cowan (City, town, or county) (State or foreign country)
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Josephine Sherman
(b) Address Indianola Iowa
17. (a) Burial (b) Date thereof May 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director et al
(b) Address Stewartsville Mo.
19. (a) 5-14-45 (b) Wm A C Hartell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10 oclock 1945 to may 10 1945 that I last saw her alive on may 9 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Thyroid gland.

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____
(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature M.S. Gale (M. D. or other) _____
Address Osborn Mo Date signed 11/1/45

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

RECEIVED
District Health Officer No. 111
District File Number
Date Filed

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 E. G. Lyon
Licensed Embalmer No. 952
P. O. Address Stewartville 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.

Registration District No. 44

Primary Registration District No. 5298

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Rural Lafayette Mo
(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 _____
years, months or days

3. (a) PRINT FULL NAME Ida Lola Worth

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

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

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

7. Birth date of deceased Mar 24
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Union Mo
(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) _____ (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) (Mrs) A. C. Hartell
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May
year 1943 hour 5:1 minute PM

21. I hereby certify that I examined the deceased from _____ 19____
that I last saw him _____ after on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____

SUPPLEMENTARY

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

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

166666