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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23079

State File No. 23084

FILED AUG - 9 1946

Registration District No. 13

Primary Registration District No. 5301

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Rural Route Three (Shawnee)
(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 years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town Cameron (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route Three
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME John W. Wormsley

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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 June 6 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Wormsley

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Bessie Thomas

(b) Address Cameron, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/31/46
(Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem, Indpls Mo

18. (a) Signature of funeral director Geo G. Carver

(b) Address Independence, Mo.

19. (a) July 31, 1946 (Date recorded local registrar) (b) Mrs Willie James (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1946 hour 9 minute 10 A.M.

21. I hereby certify that I attended the deceased from March 1st 1943 to 7-31-1946; that I last saw him alive on 7-30-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 4 days

Pulmonary edema 2 days

Due to Chronic Myocarditis and Myocardial Degeneration years _____

Due to Arteriosclerosis, Nephritis, Chronic prostatitis

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Means of injury _____

23. Signature W. Bloom (M. D. or other) W.D.

Address Cameron, Mo. Date signed 7-31-46

66 (Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Floyd C. Carson
Licensed Embalmer No. 4199
P. O. Address Independence

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Aug
620

Registration District No.

73

Primary Registration District No.

5301

Registrar's No.

620

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Rural
(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 NAMEJohn W. Wormsley3. (b) If veteran, _____
name war _____3. (c) Social Security
No. _____4. Sex m
Color or race w6. (a) Single, widowed, married,
divorced wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

June 6
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

(If less than one day

7811

min.

9. Birthplace

(City, town, or county)

(State or foreign country) Ill.

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)

Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(b)

(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 _____ Year 1942 hour _____ minute _____ M. 31

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

Due to Chronic Nephritis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 C. E. Blou (M. D. or other) 420

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

23079