

No. 2  
43  
3-17-39  
38671

FILED JUN 21 1948

Registration District No. **67** Primary Registration District No. **5265**

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

1. PLACE OF DEATH

(a) County **Christian**  
(b) City or town **Sparta Mo. Rural**  
(c) Name of hospital or institution: **Rural**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community **30 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Christian**  
(c) City or town **Sparta Mo. Rural**  
(d) Street No. **Rural**  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **W. Marion Workman**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Bertha Workman** 6. (c) Age of husband or wife if alive **67** years  
7. Birth date of deceased **March 12 1869**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **0** Days **28**  
If less than one day hr. min.

9. Birthplace **Christian Co. Mo.**  
10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_  
12. Name **Samuel Workman**  
13. Birthplace **Missouri**  
14. Maiden name **Martha McLeary**  
15. Birthplace **Missouri**

16. (a) Informant **Bertha Workman**  
(b) Address **Sparta Mo. Rural**  
17. (a) **Burial** (b) Date thereof **April 12 1947**  
(c) Place: burial or cremation **Shipman Cemetery**

18. (a) Signature of funeral director **T. B. Chaffin**  
(b) Address **Ozark, Mo.**  
19. (a) **May 31 - 480** (b) **Lillie Barr**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **10**  
year **1947** hour **1** minute **52 A.M.**  
21. I hereby certify that I attended the deceased from **Mar. 14<sup>th</sup> 1947** to **Apr. 10<sup>th</sup> 1947**  
that I last saw h. l. m. alive on **Apr. 8<sup>th</sup> 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy, Cerebral** Duration **3 days**  
Due to **Vascular Arteriosclerosis**

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 **Harold H. Kilian** M.D. or other \_\_\_\_\_  
Address **Sparta, Mo.** Date signed **May 11 48**

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

RECEIVED

District Health Officer No. 6;

District File Number 648-709

Date Filed JUN 18 1948

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. July  
Registrar's No. 8Registration District No. 67Primary Registration District No. 265

## 1. PLACE OF DEATH:

(a) County Christian  
(b) City or town Rural  
(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 days3. (a) PRINT  
FULL NAMEW. Marion Workman3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex M 5. Color or race white  
6. (a) Single, widowed, married, divorced M6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if  
alive \_\_\_\_\_7. Birth date of deceased March 12 1888  
(Month) (Day) (Year)8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_  
if less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) MO

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) May 31 - 48 (b) Lillie Barr  
(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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.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 \_\_\_\_\_

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

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

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

SUPPLEMENTARY

5-18945