

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **4105**

BIRTH NO. **FILED FEB 23 1954** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **153**

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).	
a. COUNTY <b>Buchanan</b>	b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Joseph</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Buchanan</b>
c. LENGTH OF STAY (in this place) <b>14 Yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Joseph</b> <b>0117</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>905 So. 22nd St.</b>		d. STREET ADDRESS (If rural, give location) <b>905 So. 22nd St.</b> <b>0</b>	

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) <b>SARAH</b>	b. (Middle) <b>ELIZABETH</b>	c. (Last) <b>WORLEY</b>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 6, 1954</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>July 16, 1872</b>	<b>9. AGE</b> (In years) (If under 1 year: Months) (If under 12 hrs: Days) (If under 24 hrs: Hours) (If under 60 mins: Min.) <b>81</b>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home-Maker</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Claude G. Buster</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Nancy Pickering</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>George Worley, Dec.</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. W.O. Kinsey, St. Joseph, Mo.</b>	<b>ADDRESS</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Several yrs</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Cardiovascular Renal Disease</b>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause, (a), stating the underlying cause last. <b>DUE TO (b) Arteriosclerosis Gen.</b> <b>DUE TO (c) Senile Dementia</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>442 X</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 8-10-1951, to 2-6-1954, that I last saw the deceased alive on 1-11-1954 and that death occurred at 2:30 Am., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>Robert W. Keiber, M.D.</b>	<b>23b. ADDRESS</b> <b>Kirkpatrick Bldg. St. Joseph, Mo.</b>	<b>23c. DATE SIGNED</b> <b>2-7-54</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>Feb. 9/54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Tarkio Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Tarkio, Mo.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>Feb 15, 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Betha M. Allison</b> <b>485-0</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Barry Funeral Home, St. Joseph, Mo.</b>	<b>ADDRESS</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Charles M. Harman

Licensed Embalmer No. 4487

P. O. Address Wathena, Ks.

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.