

FILED AUG 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26663

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>82</u>		PRIMARY REG. DIST. NO. <u>3017</u>		Registrar's No. <u>70</u>	
1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Boonville</u>		c. LENGTH OF STAY (In this place) <u>5 Days</u>		c. CITY OR TOWN <u>Blackwater Rural</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Joseph Hospital.</u>				e. STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Willard</u>			b. (Middle) <u>A.</u>		c. (Last) <u>Worts.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 24 1954</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 2" 1879</u>		9. AGE (In years last birthday) <u>75</u>	10. MONTHS <u>7</u>	11. DAYS <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Cooper County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>I. R. Worts.</u>		13b. MOTHER'S MAIDEN NAME <u>Laura E. Phillips.</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Elizabeth Sims Worts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Willard Worts, Boonville, Missouri.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL VASCULAR ACCIDENT.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>FIVE PREVIOUS VASCULAR ACCIDENTS.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ARICULAR FIBRILLATION OF THE HEART.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>30 YEARS</u> <u>NOT KNOWN</u> <u>NOT KNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331 X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 21, 1954</u> , to <u>Aug. 24, 1954</u> , that I last saw the deceased alive on <u>Aug. 24, 1954</u> , and that death occurred at <u>7:30 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>A. Hara, M.D.</u> (Degree or title)				23b. ADDRESS <u>0329 Main St., Boonville, Mo.</u>		23c. DATE SIGNED <u>8/26/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 27 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Old Lamine</u>		24d. LOCATION (City, town, or county) (State) <u>Cooper County, Missouri.</u>		
DATE REC'D BY LOCAL REG. <u>8-26/54</u>		REGISTRAR'S SIGNATURE <u>D. Hooper</u> <u>3810</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Goodman & Boller</u> <u>Boonville, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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

Signature of Student Embalmer

Signed

G. F. Boller

Licensed Embalmer No. *306*

P. O. Address

Boonville

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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