MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33481

1. PLACE OF DEATH
County Adair
Township ~~Long~~ Polk
City ~~Greentop~~
Registration District No. 804
Primary Registration District No. ~~[illegible]~~ 5003
(No. ..... St. ..... Ward)
File No. .....
Registered No. .....

2. FULL NAME Joseph William Voorhees
(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 21 - 1856

7. AGE YEARS 74 MONTHS 2 DAYS 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Lebanon
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lebanon
(STATE OR COUNTRY) Pa

PARENTS
10. NAME OF FATHER John A Voorhees
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lebanon
(STATE OR COUNTRY) Pa
12. MAIDEN NAME OF MOTHER Elizabeth Lehire
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) [illegible]
(STATE OR COUNTRY)

14. INFORMANT [illegible] Voorhees
(Address) Greentop Mo

15. FILED Nov 1, 1931 Mrs O P Farrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 26 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1931, to Oct 26, 1931 that I last saw him alive on Oct 25, 1931, and that death occurred, on the date stated above, at 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes & Enlargement of Liver 59
9512 (duration) 4 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 1751
Heart Lesion (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 1929 Sacrament of Polk
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) L. Hoe, M. D.
, 19 (Address) Queen City Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greentop
DATE OF BURIAL Oct 28 1931
20. UNDERTAKER L O Young
ADDRESS Greentop

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No.....

Township..... Primary Registration District No.....

City..... (No....., ...St. .....Ward)

File No.....

Registered No.....

2. FULL NAME.....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

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(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14. INFORMANT.....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS