

REC'D SEP 9 1938

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

28372

Do not use this space.

## 1. PLACE OF DEATH

(a) County Buchanan

(b) Township

(c) City St. Joseph

(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. 85

Primary Registration District No. 1001

(d) Street No. Mo. Methodist Hospital

(If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No.

865

## 2. PRINT FULL NAME

Orpha Alice Saunders

(a) Residence, No.

Cuba, Illinois

St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

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

Fasket Saunders

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 17, 1888

7. AGE

YEARS

50

MONTHS

5

DAYS

3

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown Illinois

FATHER

13. NAME Unknown Gulick

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown Unknown

MOTHER

15. MAIDEN NAME Mary Moorhouse

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown Illinois

17. INFORMANT (ADDRESS)

W. D. Saunders 2608 Prospect, Peorie, Ill.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Cuba, Ill.

DATE

Dec 1938

19. FUNERAL DIRECTOR (ADDRESS)

Hatter Meirshoffer 1302 Parson St. St. Joe, Mo.

20. FILED

Aug. 20 1938

W. D. Saunders Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 20, 1938

22. I HEREBY CERTIFY, That I attended deceased from August 20 - 1938 to August 20 - 1938

I last saw Dr alive on August 20 - 1938. Death is said to have occurred on the date stated above, at 12:00 p.m.

The principal cause of death and related causes of importance were as follows:

Fracture Skull

Date of onset 9/2/38

2:10 PM

Other contributory causes of importance:

Hemorrhage

Shock

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury Aug 20, 1938

Where did injury occur? 2 1/2 miles west of Cuba, Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Automobile accident

Nature of injury Skull Fracture

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jacob Kulevskii M. D.

(Address) Kirkpatrick Bldg

71 DM

MAY 9 1987

STATEMENT BY LICENSED EMBALMER

I, Wilbur Kelly, Licensed Embalmer No. 3946

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E. Yes

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed: Wilbur H. Kelly

Licensed Embalmer No. 3946

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

28372

Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
 (b) Township..... Primary Registration District No. 1021 Registered No. 865  
 (c) City Joseph (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alpha Alice Saunders

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.  
50 5 3

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20 1938

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. .... alive on ..... 19..... Death is said

to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Fractured skull Date of onset

Aug. 20, 1938

Other contributory causes of importance:

Hemorrhage

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Automobile accident

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Jacob Kulas M. D.

(Address) Kirkpatrick Bldg

27 8th St. W.

SUPPLEMENTARY collision with other motor vehicle.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1938

S-28372