

DEC 1 1939

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

40117  
Do not use this space.

1. PLACE OF DEATH

(a) County Laurens Registration District No. 470  
(b) Township Ant. Vernon Primary Registration District No. 5-9-33 Registered No. 161  
(c) City Ant. Vernon (d) Street No. Mo. State Sanatorium St.  
(e) Length of residence in city or town where death occurred 0 yrs. 7 mos. 15 da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Alice Lee Voorhies  
(a) Residence, No. St. Joseph, Mo. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 18, 1911

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
27 11 8

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as saw mill, bank, etc. None  
10. Date deceased last worked at this occupation (month and year) 1937 11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph Missouri

FATHER  
13. NAME John Wm Evalson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph Mo

MOTHER  
15. MAIDEN NAME Elizabeth Cross

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph Mo

17. INFORMANT (ADDRESS) Ethel McMichael Record clerk, Mt. Vernon Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph, Mo. DATE 11-26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank Funeral Home Mt. Vernon Mo.

20. FILED Nov 26, 1939 PH Palmer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4-16, 1939 to 11-26, 1939

I last saw her alive on 11-25, 1939. Death is said to have occurred on the date stated above, at 4:30 p.m.

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

Pulmonary Tuberculosis Date of onset 1936

Other contributory causes of importance: ✓

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Sputum Was there an autopsy? No

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 \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_ (Signed) J. S. ... M. D.

(Address) Mt. Vernon, Mo.

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.

RECEIVED

District Health Officer No. 6,

District File Number 1239-2457

Date Filed DEC 6 1939

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

40117

Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 470  
(b) Township St. Vernon Primary Registration District No. 5933 Registered No. 161  
(c) City ..... (d) Street No. ....  
(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 Alice Lee Voorhies

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 26 1939

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

22. I HEREBY CERTIFY, That I attended deceased from .....

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

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at.....m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
27 11 8

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

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

Date of onset

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 .....

Other contributory causes of importance:

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

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

FATHER 13. NAME .....

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

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

MOTHER 15. MAIDEN NAME .....

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

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

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

17. INFORMANT (ADDRESS) .....

Manner of injury .....

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19.....

Nature of injury .....

19. FUNERAL DIRECTOR (ADDRESS) .....

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

20. FILED Nov 26 1939 R. P. Holmes Local Registrar

If so, specify J. P. Jones M. D.

(Address) St. Vernon Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

