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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 15 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28581

Registration District No. 817 Primary Registration District No. 3063 Registrar's No. 2190

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 1406 Evergreen Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Warren Hugh Voorheis
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ruth L. Voorheis
6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased November (Month) 24 (Day) 1909 (Year)

8. AGE:	Years	Months	Days	If less than one day
	35	9	12	hr. min.

9. Birthplace Sturgeon (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Welder
11. Industry or business
FATHER
12. Name Warren Henry Voorheis
13. Birthplace Unknown (City, town, or county) Michigan (State or foreign country)
MOTHER
14. Maiden name May Winn
15. Birthplace Sturgeon (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Ruth L. Voorheis
(b) Address 5011 Claxton Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Sturgeon, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 9-11-45 (Date received local registrar) (b) E. G. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7th year 1945 hour 1 minute 15 a.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Self inflicted gunshot wound of left chest

Due to suicide 164

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence 9-7-45
(c) Where did injury occur? St. Louis (City or town) County (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home (Specify type of place)
While at work? no (e) Means of injury gunshot wound
23. Signature Arnold J. Willmann (Coroner)
Address Clayton, Mo Date signed 9-10-45

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoppe

Licensed Embalmer No. 2971

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, fact should be so stated above.