

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 2 1949

State File No. **11530**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **452**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) Lifetime		d. STREET ADDRESS (If rural, give location) 2631 State Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2631 State Street			

3. NAME OF DECEASED (Type or Print) Edwin Beck De Vorse	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) April 17 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 20, 1873	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Shipping Clerk	10b. KIND OF BUSINESS OR INDUSTRY Wyeth Hardware Co.	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME J.G. DeVorse	13b. MOTHER'S MAIDEN NAME Adelene Smith	14. NAME OF HUSBAND OR WIFE Maggie B. DeVorse
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-09-3403	17. INFORMANT'S SIGNATURE OR NAME Mrs. Stephen Lawnick	ADDRESS St. Joseph, Mo. 2631 State St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of liver		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ? DUE TO (c) General pentomas cancer		

19a. DATE OF OPERATION 4-1-49	19b. MAJOR FINDINGS OF OPERATION See # 7 + 11	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-20-49**, 1949, to **4-10-49**, 1949, that I last saw the deceased alive on **4-10-49**, 1949, and that death occurred at **8:32 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Paul Ferguson MD (Degree or title)	23b. ADDRESS St Joseph, Mo	23c. DATE SIGNED 4-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 19, 1949	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. April 25, 1949	REGISTRAR'S SIGNATURE E. G. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE Walter Meierhoffer ADDRESS 1946 Colhoun St. St. Joseph, Mo.
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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, of by *****

Student Embalmer No. *****

working under my personal supervision.

Student

Student Embalmer

Signed *Albert E. Harrington*

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, Missouri

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.