

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940
399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5609
834

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
(Specify whether
In this community Yukonaw
years, months or days)

3. (a) PRINT FULL NAME EMMA VEACH

8. (b) If veteran, name war unk. 8. (c) Social Security No. unk.

4. Sex Fe 5. Color or race wh 6. (a) Single, widowed, married, divorced separated

6. (b) Name of husband or wife Charles Veach 6. (c) Age of husband or wife if alien _____ years

7. Birth date of deceased Oct. 3 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 18 If less than one day hr. min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name unknown

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name unknown

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) burial (b) Date thereof 2-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, Kans

18. (a) Signature of funeral director W. H. Henderson

(b) Address 15th & Jackson

19. (a) Feb. 24, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 922 Van Brunt
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23rd year 1940 hour 5:50 A.M. M.

21. I hereby certify that I attended the deceased from 2-2-40, 19____, to 2-23-40, 19____; that I last saw her alive on 2-23-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy NONE

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. H. D. Manna M.D. (M. D. or other) _____
Supt. K.C. Gen. Hospital, K.C. Mo Date signed _____

Duration _____
Underline the cause to which death should be charged statistically.

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.....
Van Lawson, Apprentice....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*G. E. Hendrickson*.....
Licensed Embalmer No. *3657*.....
P. O. Address.....*K. C. Mo.*.....

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.