No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MO AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24670

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 795

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hr. (Specify whether years, months or days)
In this community 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 912 Pacific
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME INFANT VEATCH 320

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female

5. Color or race wht.

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased July (Month) 23rd. (Day) 1940 (Year)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 1 hr. 0 min.

9. Birthplace St. Joseph (City, town, or county) Mo. (State or foreign country)

10. Usual occupation infant

11. Industry or business

MOTHER FATHER

12. Name Robert Veatch

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

14. Maiden name LaVon Gibson

15. Birthplace St. Joseph (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mr. Robert Veatch
(b) Address 912 Pacific St. Joseph, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 (Month) 24 (Day) 40 (Year)
(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC
(b) Address ST. JOSEPH, MO.

19. (a) July 24-1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23rd. year 1940 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from 6:15 P.M. July 23, 1940 to 7:15 P.M. July 23, 1940 that I last saw the deceased alive on 7:10 P.M. July 23, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (5 Mos.) — Duration

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation
Of autopsy Not done

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

23. Signature R. O. Pearman (M. D. or other) M.D.
Address 825 Charles St. Date signed 7/24/40

(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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St. Joseph

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

If this body is not embalmed, fact should be so stated above.