

Registration District No. **85** Primary Registration District No. **1001**

FILED NOV 13 1940

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: **1023 1/2 Charles**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **70 years**
(years, months or days)

3. (a) PRINT FULL NAME **STERLING PRICE VESTAL**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **None**

4. Sex **male** 5. Color or race **Wht.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lydia C. Vestal** 6. (c) Age of husband or wife if alive **83** years
7. Birth date of deceased **Dec. 15th. 1861**
(Month) (Day) (Year)

8. AGE: Years **78** Months **10** Days **6** If less than one day
hr. _____ min. _____

9. Birthplace **Buchanan** **County** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **David Vestal**

13. Birthplace **unknown** **N. Carolina**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Coyle**

15. Birthplace **Independence** **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Pearl Eads**

(b) Address **1023 1/2 Charles St. Joseph**

17. (a) **burial** (b) Date thereof **Oct. 24 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Pleasant Cemetery**

18. (a) Signature of funeral director **FLEEMAN & SON INC.**

(b) Address **ST. JOSEPH MO**

19. (a) **Oct 24 1940** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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. **1023 1/2 Charles**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **21**
year **1940** hour **6** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **January 24**, 19 **40** to **October 21**, 19 **40**
that I last saw him alive on **October 21**, 19 **40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic myocarditis**
more than 9 mos.

Due to _____
Due to _____

Other conditions **arteriosclerosis general**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) _____
(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 **[Signature]** (M. D. or other) _____
Address **218 W 7th ST. JOSEPH** Date signed **10/23/40**

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

1
5
7

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

Carl W. Haus

Licensed Embalmer No.

3955

P. O. Address

St. Joseph, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34857

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Sterling Price Vestal
(b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Buchanan Co., Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
MOTHER, FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Apr. 10, 1941 (b) [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month Oct day 21 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

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 [Signature] (M. D. or other) _____
Address [Signature] Date signed _____

SUPPLEMENTARY

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

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

