

STANDARD CERTIFICATE OF DEATH

State File No. 35872

Registration District No. 281

Primary Registration District No. 4343

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Monroe  
(b) City or town Monroe City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
315 N. Locust St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20  
(Specify whether  
In this community 35 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe  
(c) City or town Monroe City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 315 N. Locust St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4  
year 1940 hour I minute 45 P. M.

21. I hereby certify that I attended the deceased from  
Sept 23, 1940 to October 4, 1940  
that I last saw him alive on October 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Duration 1 Day

Due to Chronic Myocarditis 6 Mo

Due to \_\_\_\_\_ 92 C

Other conditions Acute Bronchitis 11 Days  
(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?  
513

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Manner of injury \_\_\_\_\_

23. Signature John Stiles (M. Dr. or other) 1  
Address Monroe City Mo Date signed 11/2/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8. (a) PRINT FULL NAME Ezra Veach

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella C. 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased November 21 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 10 13 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Harrison Veach

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

14. Maiden name Dont know

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

16. (a) Informant Miss Ella C. Veach  
(b) Address Monroe City Mo

17. (a) Burial (b) Date thereof 10/6/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Judes Cemetary

18. (a) Signature of funeral director Wilson & Sox

(b) Address Monroe City, Mo

19. (a) Oct 5, 1940 (b) John Stiles  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 10

District File Number 11-40-2043

Date Filed NOV 8 1940

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 *Leslie L. Wilson*

Licensed Embalmer No. 3014

P. O. Address *Manassas City, Va*

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.