

FILED NOV. 25 1940

Registration District No. 8

Primary Registration District No. 3039

Registrar's No. 267

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Nevada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 63 yrs (Specify whether years, months or days)

8. (a) - PRINT FULL NAME Walter Steery

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

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

6. (b) Name of husband or wife A. Steery 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 21 1877
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 2 If less than one day hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business 9

12. Name Wm Albert Steery

13. Birthplace Bates Co - Mo
(City, town, or county) (State or foreign country)

14. Maiden name Susan Craig

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

16. (a) Informant Mrs. Walter Steery

(b) Address 917 N. Cherry St. Nevada, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/40
(Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Wash. Gechinger

(b) Address Nevada, Mo

19. (a) Oct 29 1940 (Date received local registrar) Allen V. Bays (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo - (b) County Vernon
(c) City or town Nevada, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 917 N. Cherry St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22 year 1940 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from June 10, 1940, to Oct 22, 1940; that I last saw him alive on Oct 22, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Post operative circulatory collapse

Duration 24 hrs

Due to _____

Due to _____

Other conditions: 127
(Include pregnancy within 3 months of death)

Major findings: Hypertrophy of prostate
Of operations Vesicle calculi
Of autopsy none made

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? 795 (Specify type of place) (e) Means of injury _____

23. Signature W. M. Steery (M. D. or other) MD

Address Nevada, Mo Date signed 10/24/40

RECEIVED

District Health Officer No. 7,

District File Number 11-40-1534

Date Filed 11-4-40

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

Mark E. Eisinger

Licensed Embalmer No. 263-6

P. O. Address Nevada, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36613

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Winn
(b) City or town Nevada
(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)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Walter Geery

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced mar

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-27-40 (b) Allen O. Gays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
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 R. W. Pearce (M. D. or other) _____

Address Nebraska _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

