

S. No. 2  
M-543  
7. 5-17-39  
P 1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40308**  
Registrar's No. **4997**

**FILED** DEC 21 1945  
Registration District No. 149

Primary Registration District No. 1002

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

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:  
General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether  
In this community 4.5 years  
years, months or days)

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. 3712 E. 51 St.  
(If rural, give location)  
(e) Citizen of foreign country? No  
(Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Veatch  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 3  
year 1945 hour 10 minute 42 P.M.  
21. I hereby certify that I attended the deceased from  
Nov. 16, 1945, to Dec. 3, 1945  
that I last saw her alive on Dec. 3, 1945  
and that death occurred on the date and hour stated above.

4. Sex Fe. / 5. Color or race Wh.  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Allen Veatch Deceased  
6. (c) Age of husband or wife if deceased years  
7. Birth date of deceased Aug - 23 - 1867  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of rectum  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 46 d

8. AGE: Years 78 Months 3 Days 10  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation House

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

MOTHER FATHER

12. Name John Arsborn

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

14. Maiden name Unknown

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

16. (a) Informant Mrs H. L. Beck

(b) Address Overland Park, Kansas

17. (a) Burial (b) Date thereof Dec-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Washington

18. (a) Signature of funeral director Wills General Home

(b) Address 2315 Lurwood H.C. 510

19. (a) 12-4-45 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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 Clark W Seely  
Address Med. Dir. Gen'l Hosp Date signed 12-3-45

**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 *Chas E. Wilks*.....

Licensed Embalmer No. *2644*.....

P. O. Address *Kansas City*.....

**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.**