No. 2
—2-43
3-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 7 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14219

Registration District No. 7-63214 Primary Registration District No. 4-45-0 6064 Registrar's No. 3 12

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Osceola (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Center
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair 3

(c) City or town Osceola "Rural" 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Harriet Ann Veach

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 17 (Day) 1854 (Year)

8. AGE: Years 91 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Canady
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mrs. Knauer
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant Enoch Veach

(b) Address Osceola Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Yeater Cemetery

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola, Missouri.

19. (a) (Date received local registrar) (b) Ruth Seevers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1946 hour 10 minute 20 A.M.

21. I hereby certify that I attended the deceased from 1-20-46, 19, to 1-24, 1946 that I last saw her alive on 1-22, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Influenza	5 da
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): age - Chronic nephritis	

Major findings:
Of operations

Of autopsy

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 0

23. Signature Ruth Seevers (M. D. or other)

Address Osceola Mo Date signed 2-10-46

288 (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.....

Licensed Embalmer No. 3038

P. O. Address.....

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.

No. 2B
1—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 314 Primary Registration District No. 606 X Registrar's No. 312

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Rural
(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 years, months or days)
In this community

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 Harriet A. Veach
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Lowe Veach
6. (c) Age of husband or wife if alive
7. Birth date of deceased Oct 17 1855 (Month) (Day) (Year)

8. AGE: Years 91 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town or county) (State or foreign country) Ill
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Ruth Seevers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 7 year 1946 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	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

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14219