

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 1 - 1957

7754

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 310

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Nodaway</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Conception Jct</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>			Length of stay in 1b <b>5 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>rural</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>GERALD</b> Middle <b>VEACH</b> Last <b>VEACH</b>				4. DATE OF DEATH <b>MARCH 7, 1957</b> Month <b>MARCH</b> Day <b>7</b> Year <b>1957</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19, 1918</b>		9. AGE (In years last birthday) <b>38</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Conception Jct., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>R. B. Veach</b>				14. MOTHER'S MAIDEN NAME <b>Dollie Wealch</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Dollie Wealch Veach, Conception Jct., Mo.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary tuberculosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>status epilepticus</b>							since childhood		
DUE TO (c) <b>had birth injury</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>1:15</b> Month <b>AM</b> Day <b>March 6, 1957</b> Year <b>1957</b>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>March 6, 1957</b> to <b>March 7, 1957</b> and last saw <b>xx</b> him alive on <b>March 7, 1957</b> . Death occurred at <b>1:15 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>G. E. Gossens MD</b>				22b. ADDRESS <b>State Hospital #2, City</b>				22c. DATE SIGNED <b>3-7-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Mar 7, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Columbia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Conception, Mo.</b>				
24. FUNERAL DIRECTOR <b>Johnson Funeral Home, Conception Jct., Mo.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Mar. 26, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		

**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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ross Johnson*

Licensed Embalmer No.....49

P. O. Address Stanberry,

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (**  
**to comply with the above constitutes grounds for revocation of license).**  
**If embalmed by a STUDENT, he also shall sign in his OWN handwriting.**  
**If this body is not embalmed, fact should be so stated above.**