

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2515  
STATE FILE NUMBER

FILED FEB 11 1958

Registration District No. 814 Primary Registration District No. 4459 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>St Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		c. CITY OR TOWN <u>Rural Osceola</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>O.M. Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>CENTER TWP</u>	
Length of stay in 1b <u>31 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>FLORENCE - VEACH</u>			4. DATE OF DEATH Month Day Year <u>FEB, 3, 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>JULY 15, 1883</u>		9. AGE (In years last birthday) <u>74</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Italy Osceola MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>FRANK HOOPER</u>	13b. MOTHER'S MAIDEN NAME <u>MATILDA SPECK</u>	14. NAME OF HUSBAND OR WIFE <u>ENOS VEACH</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ENOS VEACH</u>	Address <u>OSCEOLA MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mitral insufficiency -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs - 6 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>myocardial</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>410X</u>		19. WAS AUTOPSY PERFORMED? 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.) <u>410X</u>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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 <u>OSCEOLA MO</u>	COUNTY <u>MO</u>	STATE
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21. I attended the deceased from <u>12-30-57</u> to <u>2-3-58</u> and last saw her alive on <u>2-2-58</u> Death occurred at <u>6:30A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE (Degree or title) <u>Paul Seewers MD</u>	22b. ADDRESS <u>Osceola Mo</u>	22c. DATE SIGNED <u>2-7-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-5-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>YEATER</u>	23d. LOCATION (City, town, or county) (State) <u>OSCEOLA MO</u>
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24. FUNERAL DIRECTOR <u>Goodrich &amp; HOME-OSCEOLA MO</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-7-58</u>	26. REGISTRAR'S SIGNATURE <u>Paul Seewers</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Paul Inestore* .....

Licensed Embalmer No. *2990* .....

P. O. Address *Assees Nc* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.