

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032395

STATE FILE NUMBER

SEP 22 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 888

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY 3068 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 430 N. HARDESTY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE H. VEACH			4. DATE OF DEATH Month Day Year SEPT. 12, 1958		
--	--	--	---	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 APRIL 1906	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	---	--

13a. FATHER'S NAME THOMAS HOLT		13b. MOTHER'S MAIDEN NAME VINA SWINDELL		14. NAME OF HUSBAND OR WIFE BEN VEACH	
--	--	---	--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give year, dates of service) NO		16. SOCIAL SECURITY NO. 495-24-4707	17. INFORMANT Address HOSPITAL RECORDS
--	--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
DUE TO (b) Glioblastoma multiforme, Rt. parietal			
DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1939			

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 Month, Day, Year a.m. p.m.	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 COUNTY STATE
---	---	--	---

21. I attended the deceased from Death occurred at 9/7/58 5:35 and last saw her alive on 9/11/58	
--	--

22a. SIGNATURE (Degree or title) H. McAlhany, M.D.	22b. ADDRESS 401 Prof. Bldg. Springfield, Mo.	22c. DATE SIGNED 9/12/58
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-14-58	23c. NAME OF CEMETERY OR CREMATORY CALHOUN CEMETERY	23d. LOCATION (City, town, or county) (State) CALHOUN, MO.
--	-----------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS J. Klingner & Co. Spfld. Mo.	25. DATE RECD. BY LOCAL REG. 9-12-58	26. REGISTRAR'S SIGNATURE Offie G. Melton
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

300
1-57

1959 MAR 9 6561

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 *Glen D Williams*

Licensed Embalmer No. *4651*

P. O. Address *Springfield*

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.