

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007742
STATE FILE NUMBER
1860

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST LOUIS</i>		c. CITY OR TOWN <i>ST LOUIS</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>CITY HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>1206 N. 9th St</i>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Earnest Veal</i>			4. DATE OF DEATH Month Day Year <i>2 19 59</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-28-1915</i>
9. AGE (In years last birthday) <i>43</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life or if retired) <i>INDEX</i>	11. BIRTHPLACE (City and state or country) <i>Labor Lambert Miss</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>James Veal</i>	13b. MOTHER'S MAIDEN NAME <i>Leannae Linder Minerva Veal</i>	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>493-01-3065</i>	17. INFORMANT Address <i>Minerva Veal 1206 N. 9th</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>353.3</i>			
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? YES <input checked="" type="checkbox"/> NO <input 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 or item 18.) <i>Suffered during spasm (epileptic)</i>		
20c. TIME OF INJURY Hour a.m. <i>2 16 59</i> p.m. <i>ill home on or about Feb 16, 1959.</i>	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, school, street, office bldg., etc.) <i>52 Home</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis MO</i>		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>500A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John E. Quinn</i> (Degree or title) <i>3</i>	22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>2/21/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2-23-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oakdale Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Lemay MO</i>
24. FUNERAL DIRECTOR <i>Hill & Radford</i>	ADDRESS <i>1713 N Grand</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 21 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>

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 *Leroy W. Gunnister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.