

FILED VS SEP 2 1960 318

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8231

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Ferdinand Twp</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1660 Doris Dr.,</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>M.</b> Last <b>VEALE</b>			4. DATE OF DEATH Month <b>August</b> Day <b>21st</b> , Year <b>1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/95</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>St. Peters, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Isaac Hoffman</b>	13b. MOTHER'S MAIDEN NAME <b>Frances Treutle</b>	14. NAME OF HUSBAND OR WIFE <b>Enoch Veale</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>498-26-0115</b>	17. INFORMANT <b>Geneva Rosenkoetter, 11660 Doris Dr.,</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		<b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertrophy + Dilatation of Heart</b>	<b>3-4 years.</b>
	DUE TO (c) <b>Arteriosclerotic Heart Disease</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Marked leg edema and Varicosities</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 of item 18.) <b>4200</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from **11-27-56** to **8-21-60** and last saw her ~~him~~ alive on **8-21-60**  
Death occurred at **10:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Norman G. James, M.D.</b>	(Degree or title)	22b. ADDRESS <b>8321 N. Broadway (15)</b>	22c. DATE SIGNED <b>8-22-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>8/24/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salem Ev. Lutheran Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
 or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
 working under my personal supervision.  
 Student \_\_\_\_\_  
 Signature of Student Embalmer

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
 or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
 working under my personal supervision.

Student \_\_\_\_\_  
 Signature of Student Embalmer

Signed Elmer R. Gardner

Licensed Embalmer No. 407

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.