

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019526
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 98V- Primary Registration District No. 909F Registrar's No. 907

FILED MAY 16 1962

VS 300
Rev. 4/59

1 0581

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12 4-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Length of stay in lb <u>2 wks</u>	c. CITY OR TOWN <u>Marceline</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>130 E. Lake</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>David William Veal</u>			4. DATE OF DEATH Month Day Year <u>May 10, 1962</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/1868</u>
9. AGE (last birthday) <u>93</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>26</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Chariton, Co.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>James I.</u>	
13b. MOTHER'S MAIDEN NAME <u>Samira Woods</u>		14. NAME OF HUSBAND OR WIFE <u>Effie (dec)</u>	
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 Address <u>Mrs Verda Hatfield, Marceline, Mo</u>
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>Pulmonary Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombosis left iliac vein</u>			<u>Few hours</u>
DUE TO (c) <u>Diabetes mellitus</u>			<u>3 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
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.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>1960</u> to <u>May 1962</u> and last saw him alive on <u>9 May 62</u> Death occurred at <u></u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Blennon A. Turner, MD</u>		22b. ADDRESS <u>Marceline, Mo</u>	22c. DATE SIGNED <u>5/10/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>5/12/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locke</u>	23d. LOCATION (City, town, or county) (State) <u>Marceline, Chariton, Mo</u>
24. FUNERAL DIRECTOR <u>James M. Laughlin</u>	ADDRESS <u>Marceline, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>5-11-62</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Serald L. Wade

Licensed Embalmer No. 4172

P. O. Address Brown

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.