

FILED NOV 2 1943

Registration District No. _____ Primary Registration District No. 1000

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: Missouri Methodist Hospital
(d) Length of stay: In hospital or institution 56 years
In this community 56 years

3. (a) PRINT FULL NAME Robert Q. Vestal
3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maie 6. (c) Age of husband or wife if alive years
7. Birth date of deceased January 3 1887

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>9</u>	<u>24</u>	hr. _____ min.

9. Birthplace Buchanan County Mo

10. Usual occupation Farmer

11. Industry or business _____
12. Name James Vestal
13. Birthplace Buchanan Co Mo
14. Maiden name Sarah Ferrel
15. Birthplace Buchanan Co Mo

16. (a) Informant Maie Vestal
(b) Address Halls Mo

17. (a) Burial (b) Date thereof 10-30-43
(c) Place: burial or cremation Deacon's Mo

18. (a) Signature of funeral director Barry Funeral Home
(b) Address 218 South 10th St St Joseph Mo

19. (a) 10-30-43 (b) Rose Heigsoy

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph Halls
(d) Street No. _____
(e) Citizen of foreign country? No

20. DATE OF DEATH: Month Oct day 27
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 25 1943 to Oct 27 1943
that I last saw him alive on Oct 27 1943
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis
Due to Ruptured gastric ulcer
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Ruptured Gastric Ulcer
Of operations ulcer
Of autopsy General Peritonitis, Ch. Granular Hypertrophy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature H. W. Kearby (M. D. or other)
Address St Joseph Mo Date signed 10-29-43

Duration 3 da.
2 da.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

1235

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Mollie E. Siderofadew*

Licensed Embalmer No. *42315*

P. O. Address *St. Joseph, Mo*

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