V. S. No. 2
0M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28240

FILED AUG 18 1945

Registration District No. 271 Primary Registration District No. 5988 Registrar's No. 44

1. PLACE OF DEATH:
(a) County Putnam
(b) City or town Elm. Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ########
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Putnam 86
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) ~~Street No.~~ #### Near Worthington Mo. 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wayne Leon Veach
3. (b) If veteran, name war
3. (c) Social Security No. 481-14-6259
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clarice Veach
6. (c) Age of husband or wife if alive 20 years
7. Birth date of deceased 10 (Month) 11 (Day) 1919 (Year)

8. AGE: Years 25 Months 8 Days 23 If less than one day ___ hr. ___ min.

9. Birthplace Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation Miner
11. Industry or business
FATHER
12. Name Frebern Veach
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
MOTHER
14. Maiden name Maud McFarland
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)
16. (a) Informant Clarice Veach
(b) Address Worthington Mo.
17. (a) Br. (Burial, cremation, or removal) (b) Date thereof 7-5-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Cem.
18. (a) Signature of funeral director Husted & Son
(b) Address Unionville Mo.
19. (a) July 17 45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th year 1945 hour 3.15 minute A M.
21. I hereby certify that I attended the deceased from Feb 1945 to July 4 1945 that I last saw him alive on June 29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	One year
Due to ✓	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy ✓	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence ✓
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature H T Garrison (M. D. or other)
Address Noringer Mo Date signed 7-5-45

(Licensed Embalmer's Statement on Reverse Side)

AUG 31 1949

MAR 20 1962

RECEIVED
District Health Officer No. 10
District File Number 8-45-1211
Date Filed AUG 16 1945

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 F. O. Husted

Licensed Embalmer No. 2975

P. O. Address Unionville, 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.