

Registration District No. 175

Primary Registration District No. 2036

Registrar's No. 118

**1. PLACE OF DEATH:**  
 (a) County Lawrence  
 (b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
227 E. College St  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 6 yrs 6 mo  
years, months or days)

**3. (a) PRINT FULL NAME** Irene Wright Veale

3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Robert R Veale  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 29 1861  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 6  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Knoxville Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William B Wright

{ 13. Birthplace Knoxville Ill.  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Malinda E Anderson

{ 15. Birthplace Knoxville Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs O.E. Moore

(b) Address Aurora Mo.

17. (a) Removal (b) Date thereof 12/8/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Star Mo.

18. (a) Signature of funeral director J.T. King  
 (b) Address Aurora Mo.

19. (a) 12-8-1945 (b) Dora McMill  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Lawrence  
 (c) City or town Aurora  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 227 E. College St  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 5  
 year 1945 hour 3 minute 15 P M.

21. I hereby certify that I attended the deceased from 5-8 May  
8 1944, to Nov 18 1945  
 that I last saw h. er alive on Nov 18 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch myeloiditis  
 Duration ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 R.D. ... (M. D. or other) \_\_\_\_\_  
 Address Aurora Mo. Date signed 12/6/45

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 146-14

Date Filed JAN 8 1946

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 *Herman Surrig*

Licensed Embalmer No. 3072

P. O. Address Aurora 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.