No. 2
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1947

Registration District No. 9947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27295

Primary Registration District No. 41-68-5373

Registrar's No. 99

1. PLACE OF DEATH:

(a) County: De Kalb

(b) City or town: Maysville — Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: / In this community: Life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: De Kalb

(c) City or town: Maysville — Rural
(If outside city or town limits, write "RURAL")

(d) Street No.:
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Walter Gray Veale

3. (b) If veteran, name war:

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: Neva May Veale

6. (c) Age of husband or wife if alive: 52 years

7. Birth date of deceased: Nov, 7 1879
(Month) (Day) (Year)

8. AGE: Years: 67 | Months: 8 | Days: | If less than one day: hr. min.

9. Birthplace: Union Star (City, town, or county) — Mo. (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: John Veale
13. Birthplace: (City, town, or county) — Virginia (State or foreign country)

MOTHER
14. Maiden name: Annie Jinkens
15. Birthplace: (City, town, or county) — Virginia (State or foreign country)

16. (a) Informant: Neva May Veale

(b) Address: Maysville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8 9 1947 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: John D Brann

(b) Address: Maysville Mo

19. (a) 8-9-47 (Date received local registrar) (b) R Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 7
year: 1947 hour: 5 minute: 10 P.M.

21. I hereby certify that I attended the deceased from Aug 2, 1947, to Aug 7, 1947, that I last saw him alive on Aug 7 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: cerebral Hemorrhage	5 days
Due to: arteriosclerosis	?
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:

(a) 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?

While at work? (Specify type of place) (e) Means of injury: 2

23. Signature: H. Jerald Hostler (M. D. or other)

Address: Maysville Mo Date signed: 8-8-47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 John G Brown

Licensed Embalmer No. 3933

P. O. Address Maysville 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.