

FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39268**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **2545**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Rock Hill		c. LENGTH OF STAY (in this place) 1 year	c. CITY OR TOWN Oakland Village ⁴⁷⁸⁸
d. FULL NAME OF HOSPITAL OR INSTITUTION Rock Hill Nursing Home		e. STREET ADDRESS (If rural, give location) 405 Miriam	

3. NAME OF DECEASED (Type or Print) Minnie	a. (First)	b. (Middle) C.	c. (Last) Veach	4. DATE OF DEATH (Month) (Day) (Year) Nov. 1, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 11, 1866	9. AGE (in years last birthday) 89	10. IF UNDER 1 YEAR Months	11. IF UNDER 1 YEAR Days	12. IF UNDER 1 YEAR Hours	13. IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Versailles, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME George Harroun	13b. MOTHER'S MAIDEN NAME Olive Sturdivant	14. NAME OF HUSBAND OR WIFE Charles
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Enid Robinson, 405 Miriam Ave.	ADDRESS
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18. CAUSE OF DEATH PER LINE FOR (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic myocarditis		
	ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4221	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 26, 1951**, to **Nov 1, 1955**, that I last saw the deceased alive on **Oct 31, 1955**, and that death occurred at **6:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE C. J. Werlein M.D. (Degree or title)	23b. ADDRESS 350.7 Poloma	23c. DATE SIGNED 11-2-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-2-55	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Grafton, Ill.
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DATE REC'D BY LOCAL REG. 11-2-55	REGISTRAR'S SIGNATURE Albert H. Hoppe MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Elmer R. Padwell*.....

Licensed Embalmer No. *407*.....

P. O. Address *H. Lor*.....

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.