

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

32824
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 470
 (b) Township W. Vernon Primary Registration District No. 3-1033 Registered No. 122
 (c) City W. Vernon (d) Street No. Missouri State Sanatorium St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. 1 mos. 1 ds. 22 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alfred Michael Venne, Jr

(a) Residence, No. Hannibal, 613 Hill St St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF -----		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 19, 1908		
7. AGE	YEARS 30	MONTHS 14
		DAYS 14
		IF LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year) 1930	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) Philadelphia (STATE OR COUNTRY) Penna		
FATHER	13. NAME Alfred M. Venne	
	14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) North Dakota	
MOTHER	15. MAIDEN NAME Sarah Williams	
	16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) New York	
17. INFORMANT E. McMichael, Record Clerk (ADDRESS) Missouri State Sanatorium		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>W. Vernon City Cem</u> DATE <u>9/2/39</u>		
19. FUNERAL DIRECTOR (NAME) Geo. B. Omb (ADDRESS) <u>W. Vernon</u>		
20. FILED <u>Sept 2, 1939</u> <u>P. D. Holm</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 1, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **July 9, 1938** to **Sept 1, 1939**
 I last saw him alive on **Sept. 1, 1939** Death is said to have occurred on the date stated above, at **6:40p** m.
 The principal cause of death and related causes of importance were as follows:

Pharynx
Tuberculosis
J.P.
Other contributory causes of importance:
The meningitis
Open Nephrectomy
Name of operation *Nephrectomy* Date of
What test confirmed diagnosis? Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury....., 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify.....
(Signed) *Chas. J. Peeler*, M. D.
(Address) *W. Vernon*

Date of onset
1930

WRITE PLAINLY, WITHOUT STAMPING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,
District File Number 1039-1966
Date Filed OCT 5 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32824
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 470
(b) Township 7 mt Vernon Primary Registration District No. 5623 Registered No. 129
(c) City..... (d) Street No.....
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Alfred Michael Kenne Jr.
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 19 1908

7. AGE YEARS MONTHS DAYS
30 - 12
IF LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sep 2 1939 P. Palmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 1 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Chester J. Melton, M. D.

(Address) mt Vernon Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

DATE: 10/15/64

SUBJECT: [Illegible]

[Illegible]