

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **26131**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 961			
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 20 years		c. CITY OR TOWN St. Joseph		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hospital				e. STREET ADDRESS (If rural, give location) 3514 Mitchell Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Eva b. (Middle) May c. (Last) Vencill			4. DATE OF DEATH (Month) (Day) (Year) Aug. 31, 1956						
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH April 22, 1882			
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Sullivan Co., Missouri			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY housework		11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Samuel Pratt			13b. MOTHER'S MAIDEN NAME Jane Wade			14. NAME OF HUSBAND OR WIFE Ezekiel Vencill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Wayne Vencill ADDRESS 3514 Mitchell St. Joseph, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION					
This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage anuria		INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
				ANTECEDENT CAUSES		DUE TO (b) hypertension			
				DUE TO (c) Fractured hip					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION 8/27/56		19b. MAJOR FINDINGS OF OPERATION fracture of left hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Joseph Buchanan Mo.					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 16, 1956 9am m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fell to floor					
22. I hereby certify that I attended the deceased from 1/7/55, 19 , to 8/31/56 , 19, that I last saw the deceased alive on 8/31/56 , 19, and that death occurred at 9:45A m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>Walter M. Allison</i>				23b. ADDRESS 218 North 7th St. Joseph, Mo.		23c. DATE SIGNED 9/1/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9/1/1956		24c. NAME OF CEMETERY OR CREMATORY Galt, Missouri		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. Sept 7, 1956		REGISTRAR'S SIGNATURE <i>Cashed M. Allison</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter M. Allison</i> ADDRESS St. Joseph, Mo.					

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

4850

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 *William Spedding*.....

Licensed Embalmer No. *4535*.....

P. O. Address *319 S 10th St*.....

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.