

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 043995

FILED VS JAN - 4 1960

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. Registrar's No. 225

ENDED

1. PLACE OF DEATH a. COUNTY <i>Grundy</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>mo</i> b. COUNTY <i>Grundy</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Genton</i>		Length of stay in 1b <i>1 wk.</i>		c. CITY OR TOWN <i>Galt</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Plaquemine Rest Home</i>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>SILAS VENCILL</i>				4. DATE OF DEATH Month Day Year <i>12-28-1959</i>					
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>9-8-1879</i>	9. AGE (last birthday) <i>80</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Grundy Co mo</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>John Vencil</i>			13b. MOTHER'S MAIDEN NAME <i>Florance Sully</i>			14. NAME OF HUSBAND OR WIFE <i>Peachie Vencil</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs Peachie Vencil Galt mo</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Dec 28-59</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Reoccurring Cerebral Hemorrhage</i>					<i>Nov 1-59</i>		
		DUE TO (c) <i>Cerebral Hemorrhage</i>					<i>Oct 1959</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <i>July 1950</i> to <i>December 1959</i> and last saw her alive on <i>Dec 28-59</i> Death occurred at <i>4:15 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>A. W. Winters</i> (Name or title)				22b. ADDRESS <i>Mo Galt</i>			22c. DATE SIGNED <i>MO</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)		
<i>Burial</i>	<i>12-30-59</i>	<i>Galt Cemetery</i>			<i>Galt</i>		<i>mo</i>		
24. FUNERAL DIRECTOR ADDRESS <i>R. K. Payne 400 Galt mo</i>				25. DATE RECD. BY LOCAL REG. <i>12-30-59</i>		26. REGISTRAR'S SIGNATURE <i>Jane Fair</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *James R. Piggan*

Licensed Embalmer No. 3792

P. O. Address *Melrose, Me*

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.