

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-047068

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1530

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED JAN 3 1966

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>6 Weeks</u>	c. CITY OR TOWN <u>Cosby</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>811 North 9</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Cosby, Mo.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>H.</u> Last <u>Vennekohl</u>			4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1965</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1887</u>	9. AGE (last birthday) <u>78 Years</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cosby, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Henry Vennekohl</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Dersch</u>		14. NAME OF HUSBAND OR WIFE <u>Pearl Vennekohl</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.# 1</u>	16. SOCIAL SECURITY NO. <u>491-42-0244</u>	17. INFORMANT <u>Mrs. Pearl Vennekohl; Cosby, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Progressive cerebral arterial vascular insufficiency</u>		<u>Months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral vascular arteriosclerosis</u>	<u>Years</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease; Cardiac insufficiency; Severe emphysema.</u>		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
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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 <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from 1960, to 12/27/65 and last saw ^{xx}him alive on 11/29/65
Death occurred at 1:30 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Caryl E. Potter, Jr. M.D.</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>510 Francis, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>12/28/65</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/29/1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>E.U.B. Cemetery</u>	23d. LOCATION (City, town, or county) <u>Cosby, Mo.</u>
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24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Dec. 29-1965</u>	26. REGISTRAR'S SIGNATURE <u>Mary Vallentine</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

C. A. POTTER JR., M.D., MEDICAL CERTIFICATION

JAN 1 1968

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 *Robert H. Kelly*

Licensed Embalmer No. 5220

P. O. Address *St Joseph 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.