

FILED AUG 28 1945

Registration District No. 57

Primary Registration District No. 4094

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Barden City mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass 19
(c) City or town Barden City (If outside city or town limits, write "RURAL.") 0
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? U.S. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME VENA FAYE KENAGY.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Charles Kenagy 6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased June 23 1908
(Month) (Day) (Year)

8. AGE: Years 37 Months 1 Days 13
If less than one day hr. _____ min. _____

9. Birthplace Austin, mo (City, town, or county) (State or foreign country) 0

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Tom Leavell
13. Birthplace mo (City, town, or county) (State or foreign country) 0
14. Maiden name Maudie Leavell
15. Birthplace mo (City, town, or county) (State or foreign country) 0

16. (a) Informant Charles Kenagy
(b) Address Barden City mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 45
(Month) (Day) (Year)
(c) Place: burial or cremation Barden City, Austin

18. (a) Signature of funeral director M. Kaufman
(b) Address Barden City mo

19. (a) Aug 11, 1945 (Date received local registrar) (b) Margaret Tolle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6 year 1945 hour 2 minute 2 M.

21. I hereby certify that I attended the deceased from July 1, 1945, to Aug 3, 1945.
that I last saw her alive on Aug 3, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis (non-specific) Duration 5 days
Due to Fungus infection of lungs 26 yrs.

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy gout
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury 2

23. Signature D.P. Colson (M. D. or other) 00
Address Adrian mo Date signed 8-8-45

WRITE PLAINLY—USE 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 _____, Registered-Apprentice No. _____, working under my personal supervision.

Signed

J. M. [Signature]

Licensed Embalmer No. 1039

P. O. Address: Garden City

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, fact should be so stated above.