

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29269

State File No. ....

FILED AUG 17 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 887 PRIMARY REG. DIST. NO. 5676 Registrar's No. 144

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

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Jackson Twp.</u>	c. LENGTH OF STAY (In this place) <u>56 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Jackson Twp.</u> <u>059d</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7 mi. N.W. Chillicothe</u>		d. STREET ADDRESS (If rural, give location) <u>7 mi. N.W. Chillicothe</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Casper</u>	b. (Middle) <u>Bernard</u>	c. (Last) <u>Wenke</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 8, 1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 23, 1871</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Ft. Madison, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Bernard W. Wenke</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Rosen</u>	14. NAME OF HUSBAND OR WIFE <u>Emma Wenke</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u> <u>XX</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Emma Wenke-Chillicothe, Mo.</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Aortic stenosis</u>		<u>10 yrs.</u> <u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Benign Prostatic Hyperplasia</u>		<u>6 yrs.</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	20. AUTOPSY? <u>331X</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 6 July, 1953, to 8 Aug, 1953, that I last saw the deceased live on 6 Aug, 1953, and that death occurred at 11:15 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	23b. ADDRESS <u>Chillicothe Mo.</u>	23c. DATE SIGNED <u>10 Aug 53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 12, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Columban</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Aug-10-53</u>	REGISTRAR'S SIGNATURE <u>Francis B. Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Godaa</u> ADDRESS <u>Chillicothe, Mo.</u>
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SEP 25 1953

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 .....  
Student Embalmer

Signed Donald G. Shaw

Licensed Embalmer No. 4191

P. O. Address Phillips 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 this body is not embalmed, fact should be so stated above.