AY 29 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

20431

1. PLACE OF DEATH
County Shelby — Registration District No. 830 — File No. 19
Township Lentner — Primary Registration District No. 6091 — Registered No.
City Shelbina (No. ..... St. ..... Ward)

2. FULL NAME James K Kent
(a) Residence No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 4-1842

7. AGE: Years 87 — Months 2 — Days 19 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

PARENTS
10. NAME OF FATHER Kennis Kent
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Rebecca Wheelbarger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT J. A. Kent
(Address) Shelbina, Mo

15. FILED May 10, 1929 Madge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23-1929

17. I HEREBY CERTIFY, That I attended deceased from 5-21-, 1929, to 5-23-, 1929 that I last saw him alive on 5-23-, 1929, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage.
82H
97 (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) arterio-sclerosis
74 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. M. Wood, M. D
, 19 (Address) Shelbina Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Crooked Creek — DATE OF BURIAL: Apr. 25 1929.

20. UNDERTAKER: J B Brothers — ADDRESS: Shelbina

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.