

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

Do not use this space.

25240

**1. PLACE OF DEATH**

County Marion Registration District No. 547 File No. \_\_\_\_\_  
 Township Marion Primary Registration District No. 5938 Registered No. 186  
 City ~~Marion~~ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Priscilla Gracey Dent  
 (a) Residence. No. RR # Hannibal St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug. 21. 1866</u>		
7. AGE	YEARS	MONTHS
<u>63</u>	<u>11</u>	<u>4</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Retired Home Wife</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) _____		
(c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) Emerson  
 (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER <u>Gas. Scott</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Martha Johnson</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)

14. INFORMANT Mrs. Paul St. John  
 (Address) RR # Hannibal, Mo.

15. FILED 7/26 1929 C. Clausen  
 REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-25-1929  
 17. I HEREBY CERTIFY, That I attended deceased from April 15, 1926, to July 23, 1929, that I last saw him alive on July 25, 1929, and that death occurred, on the date stated above, at 5:20 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: 718  
1620  
Senile Dementia,  
 (duration) 2 yrs. mos. ds.

CONTRIBUTORY Amnesia  
 (SECONDARY) (duration) 1 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 \_\_\_\_\_  
 (Signed) J. C. Pittman, M. D.  
 , 19 (Address) Hannibal

\*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 St. John's Cemetery DATE OF BURIAL 7-28-1929  
 20. UNDERTAKER James O'Donnell ADDRESS Hannibal

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**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Marion Registration District No. 547 File No. \_\_\_\_\_  
 Township marion Primary Registration District No. 5738 Registered No. 186  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Opiscilla Gracey Dent

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 21 - 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
63 11 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15. FILED 7-26-29 CE Cousins REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 - 1929

17. I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-25240