

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

Do not use this space.

12474

1. PLACE OF DEATH

County Jackson

Registration District No. 396

Township Fort Osage

Primary Registration District No. 3337

City _____ (No. _____)

File No. _____

Registered No. 7

St. _____ Ward _____

2. FULL NAME

Columbus Denton

(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 52 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) Amanda Jones Denton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20, 1853

7. AGE YEARS 77 MONTHS 0 DAYS 23 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Beaty, Arkansas

(STATE OR COUNTRY)

10. NAME OF FATHER John William Denton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tennessee

(STATE OR COUNTRY)

14. INFORMANT John Denton

(Address) Buckner mo.

15. FILED 5-10 1930 N. W. Hamcraft REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12, 1930

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to April 11, 1930 that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 7 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Regurgitation

92A

CONTRIBUTORY (SECONDARY)

90 W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Chinical
(Signed) N. W. Hamcraft M. D.

5-10, 1930 (Address) Buckner 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

Six Mile Cemetery

DATE OF BURIAL

April 13, 1930

20. UNDERTAKER

V. M. Reppert

ADDRESS

Buckner

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

