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

Do not use this space.

18025

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. ..... St. ..... Ward)

File No. .....

Registered No. 5179

2. FULL NAME Wm M. Dent

(a) Residence (Usual place of abode) Rear 4490 Forest Park Blvd Ward 19 (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Col.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 25-1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
49	✓	8	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor 95B 82A

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Knoxville (STATE OR COUNTRY) Tenn.

PARENTS

10. NAME OF FATHER Don't Know

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

12. MAIDEN NAME OF MOTHER Kathie Dent

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

14. INFORMANT Lena Dent (Address) 4490 Rear Forest Park Blvd.

15. FILED MAY 27 1930 19 Mary C. Harley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to May 20, 1930 that I last saw h'm alive on May 24, 1930 and that death occurred, on the date stated above, at 2:18 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Chronic Sciatica cause unknown Hypertrophy Heart (duration) ..... yrs. 9 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Vincent J. Mueller M. D.

Nov. 24, 1930 (Address) 2335 Franklin

*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
Father Dickson	May 20 1930
20. UNDERTAKER	ADDRESS
Elmer E. Pettis	3030 Bell Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 883 Registered No. 5179

City St. Louis (No. ..... St. ..... Ward)

2. FULL NAME Wm. M. 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 M

4. COLOR OR RACE Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 25 1881 1889

7. AGE YEARS 49 MONTHS 8 DAYS 25 IF LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

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 JUL -3 1930 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1930

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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

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.

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