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

Do not use this space.

23020

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis (No. De Paul Hospital ..... St. ..... Ward)

File No. .....

Registered No. 6463

2. FULL NAME Brent Mrs Agnes K.

(a) Residence: No. 28 North Clay - Ferguson Mo. (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? 81 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thos G Brent Dec

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dont Know

7. AGE: abt. 81

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home retired

(b) General nature of industry, business, or establishment in which employed (or employer): House wife 23

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo ? 1

PARENTS

10. NAME OF FATHER: M J Kennett

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

12. MAIDEN NAME OF MOTHER: Dont Know

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

14. INFORMANT: Miss Violet Frost (Address) Same Ferguson Mo

15. FILED 10 [illegible] Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/10 1931

17. I HEREBY CERTIFY, That I attended deceased from Mch 10, 1931, to June 9, 1931, that I last saw her alive on June 9, 1931, and that death occurred, on the date stated above, at 7:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch Myocarditis

131 Sclerotic

93c Delilation

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Ch Glomerulo

Nephritis (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 DIAGNOSIST? Lab

6/10 1931 (Signed) E P Buddy M.D.

(Address) Univ Club Bl

*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: Bellefontaine

DATE OF BURIAL: June 11 1931

20. UNDERTAKER: Cullen & Kelly

ADDRESS: 1416 N Taylor Ave

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.