

REC'D FEB 16 1939

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

2464
 Do not use this space.

1. PLACE OF DEATH *Lukery 2*

(a) County *Lukery* Registration District No. *365*

(b) Township *Wheatland* Primary Registration District No. *5511*

(c) City *Wheatland Mo* Street No. _____ Registered No. *2*

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

2. PRINT FULL NAME *530 now P. Dent*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *wht* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr 16, 1858*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>80</i>	<i>9</i>	<i>11</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

FATHER

13. NAME *Saul Dent*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER

15. MAIDEN NAME *Mary Brown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Margie Rensis Wheatland Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Summer* DATE *1/30 39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J.R. Luckey Wheatland Mo*

20. FILED *2-4* 1939 *Mrs. A. S. Johnston* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 27, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Jan - 26 -*, 1939, to *Jan - 27*, 1939

I last saw him alive on *Jan - 27*, 1939 Death is said to have occurred on the date stated above, at *7:00* m.

The principal cause of death and related causes of importance were as follows:

Paralysis Date of onset *1-26-39*

Due to Cerebral Hemorrhage

J.J.M.

Other contributory causes of importance: *Previous attack several years ago*

Name of operation _____ Date of _____

What test confirmed diagnosis? *Physical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify _____

(Signed) *A. S. Johnston*, M. D.

(Address) *Wheatland Mo*

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.

STATEMENT BY LICENSED EMBALMER
CERTIFICATE OF DEATH AND BURIAL
STATE OF ILLINOIS

RECEIVED
District Health Officer No. 7.
District File Number 1-29-189
Date Filed 2-6-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.