

FILED MAR 9 - 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

6034

Registrar's No.

239

Registration District No.

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. Methodist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community 40 years
 years, months or days)

3. (a) PRINT FULL NAME CHARLES G. KENT

8. (b) If veteran, name war World 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mildred Kent 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Feb. 20 1890
 (Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 9 If less than one day
 hr. _____ min. _____

9. Birthplace Denver Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Live Stock Comm. Co. Mgr.

11. Industry or business Kent Comm. Co.

MOTHER FATHER { 12. Name Luther Kent
 18. Birthplace Denver Mo.
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mattie Bell Spann
 16. Birthplace Unknown Indiana
 (City, town, or county) (State or foreign country)

16. (a) Informant Mildred Kent
 (b) Address 2946 Charles St. Joseph, Mo.

17. (a) Burial (b) Date thereof Feb. 29 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director FLEEMAN & SON, INC.
 (b) Address St. Joseph, Mo.

19. (a) Feb 29 1940 (b) Z. J. Neettlebush
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2946 Charles
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27
 year 1940 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from Feb. 25, 26
 1940 to Feb 26, 1940

that I last saw him alive on Feb. 27, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage
 Due to Brain Tumor

Due to Spongy Degeneration
or Hemiparesis

Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: no operation
 Of operations _____

Of autopsy as above
Microscopic Section not yet reported
 Underline the cause to which death should be attributed.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident?

(b) Date of occurrence 1939

(c) Where did injury occur? Denver Col.

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Highway - Automobile

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Z. J. Neettlebush (M. D. _____)

Address 825 Charles St. Joseph Date signed 2/29/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

See affidavit no 250 in misc file. 1940
also see no 252 " " " " 11

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: *C. H. Swan*
Licensed Embalmer No. *4082*
P. O. Address: *St Joseph*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6034**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **85-**

Primary Registration District No. **1001**

Registrar's No. **239**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Beychanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Charles G Kent**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
50 0 9

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **4/11/40** (b) **AJ Nestlebud**
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U.S.A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **2** day **29**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage

Due to **Brain Tumor, Blastoma**

Due to **Patient simply had a spontaneous hemorrhage of the brain.**

Other conditions (Include pregnancy within 5 months of death)

Major findings: **No operation**

Of operations **microscopic, not yet revealed**
Of autopsy **non microscopic (Spongio Blastoma Multiforme)**

Duration

PHYSICIAN

Underline cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **not due to accident.**

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature **D. G. Thompson** (M. D. or other)

Address **St. Joseph, Mo.** Date signed _____

SUPPLEMENTARY

