

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18675**
Registrar's No. **42**

Registration District No. **404** Primary Registration District No. **555-X**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Rural Washington**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Year**
In this community **17 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Bayard T. Brent**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **653**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Oct. 15 1861**
(Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **24** If less than one day hr. _____ min. _____

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

10. Usual occupation **Farmer**

11. Industry or business **Retired 17 years**

12. Name **John Brent**

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

14. Maiden name **Mary Sullivan**

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

16. (a) Informant **Guy Brent**

(b) Address **134 E. 65th Terrace**

17. (a) **Burial** (b) Date thereof **May 10, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cem.**

18. (a) Signature of funeral director **Walter Hummel**

(b) Address **7406 Wornall Road**

19. (a) **3-15-** (b) **W. J. Brennan**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **7842 Wornall Road**
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8th**
year **1940** hour **11** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **4-25-40**
_____ 19____ to **5-8-** 19____

that I last saw him alive on **5-8-** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Respiratory - renal
vascular disease
acute myocardial
infarction
Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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

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

(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?
366

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

23. Signature **W. H. W. W.** (M. D. or other) _____

Address **3850 Prospect** Date signed _____

Duration

2

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Bremson

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.....

Harlem Rose

Licensed Embalmer No. *7810*

P. O. Address.....

Panama City, Me

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.