

NEW JAN - 6 1944  
Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 1425

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution McLarny Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

8. (a) PRINT FULL NAME James Franklin Kent

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 25 1874  
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 22 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph Kent

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

14. Maiden name Marion Cyle

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

16. (a) Informant's own signature J. H. Hunt

(b) Address Brookfield Mo.

17. (a) Burial (b) Date thereof Dec 19 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo.

18. (a) Signature of funeral director Wm. W. Cowden

(b) Address Brookfield Mo.

19. (a) 12-19-42 (b) W. W. Cowden  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn  
(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 809 Mead  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17  
year 1942 hour 7 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 12/15/42 to 12/17/42  
that I last saw him alive on 12/17/42  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 2 da

Due to Acute renal failure of uremia

Due to Hypertension - Poor diet 6 mo

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations 0

Of autopsy 0 13562

PHYSICIAN  
Underline the 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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature J. H. Hunt (M. D. or other)

Address Brookfield Mo. Date signed 12/19/42

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

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.

Rev. 5-17-39 I 10511

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**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.**