

FILED JAN 12 1944

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH
(a) County **Richman**
(b) City or town **St. Joseph**
(c) Name of hospital or institution: **State Hosp. N. 2 2**
(d) Length of stay: **6 years into 3 days**
In this community **6 years into 3 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Ray**
(c) City or town **Richman**
(d) Street No. _____
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Denton**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 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 **unknown**
(Month) (Day) (Year)

8. AGE: Years **abt 58** Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace **unknown Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **none**

MOTHER FATHER

11. Industry or business _____
12. Name **David Rice Denton**
13. Birthplace **Kentucky**
14. Maiden name **Mare Slaughter**
15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Denton (Brother)**
(b) Address **Richmond Mo**
17. (a) **Removal** (b) Date thereof **12-24-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Richmond mo**
18. (a) Signature of funeral director **Thurman**
(b) Address **Richmond mo**
19. (a) **12-24-43** (b) **Rose Heagy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **24th** year **1943** hour **3** minute **30 A** M.
21. I hereby certify that I attended the deceased from **November 16th 1943** to **Dec. 24 1943**
that I last saw him alive on **December 23rd 1943** and that death occurred on the date and hour stated above.
Immediate cause of death **Gonorrheal pneumonia** Duration **9 days**
bronchomatous nephritis
Due to **Myocarditis** **a few days**
Due to **Mental Deficiency with Cerebral Arteriosclerosis**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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) _____
(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. E. Coombs** (M. D. or other) _____
Address **State Hospital St. Joseph Mo** Date signed **12-24-43**

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

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

Will be embalmed by me

Registered Apprentice No.

working under my personal supervision.

Signed

E. Sherman

Licensed Embalmer No. *2077*

P. O. Address *Richmond, Va.*

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, fact should be so stated above.

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