

FILED JAN 8 1946

STANDARD CERTIFICATE OF DEATH

State File No. **40592**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1391**

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 6 hrs
(Specify whether)
 In this community 37 years
years, months or days

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. 1209 Washington
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name & country _____

3. (a) PRINT FULL NAME CHARLES W. LENT

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race SW 6. (a) Single, widowed, divorced, Widowed
 6. (b) Name of husband or wife Josephine 6. (c) Age of husband or wife if alive Deceased years
 Birth date of deceased NOV. 25 1854
(Month) (Day) (Year)

8. AGE: Years 91 Months 0 Days 26 If less than one day
hr. min.

9. Birthplace Canada 12
(City, town, or county) (State or foreign country)

10. Usual occupation Produce Market

11. Industry or business retired

12. Name David Lent

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

14. Maiden name Hariett Vanozen

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

16. (a) Informant Mrs. Boulah Hocker daughter

(b) Address Industrial City, MO.

17. (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery Rupp Funeral Home

18. (a) Signature of funeral director PRYOR, ST. JOSEPH MO

(b) Address St. Joseph

19. (a) Dec 27, 1945 (b) W. Hestebial
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21st
 year 1945 hour 11 minute 4.5 P.M.

21. I hereby certify that I attended the deceased from 12/17
 1945, to 12/21 1945
 that I last saw him alive on 12/21 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
 Duration _____

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) NO

(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 W. Hestebial (M. D. or other) _____

Address: 266 St. Joseph Date signed 1/7/46

ADDITIONAL SUPPLEMENTARY INFORMATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

1428

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 Mollie E. Sidenfaden
Licensed Embalmer No. 4235
P. O. Address St. Joseph, Mo.

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.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1391

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:
Ma Methodist Hospital
 (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 W. Lent

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 wid

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

7. Birth date of deceased Nov 25 1895
 (Month) (Day) (Year)

8. AGE: Years 91 Months 10 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
 (Date received 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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Bilateral Lobes
Pneumonia

Duration _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy 108

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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 J. Stamer (M. D. or other) _____

Address 2634 St Joseph Ave Date signed 11/17/46

SUPPLEMENTARY

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

3880

40592