

FILED JAN 7 1947
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11275**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **ST. LOUIS MO**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Infirmiry Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12/5/46 to 12/29/46**
In this community **12/29/46**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5529 Vernon**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Agnes May Dent**

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

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

6. (b) Name of husband or wife **ELLIS J. DENT** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **May, 6, 1873**
(Month) (Day) (Year)

8. AGE: Years Months **73** Days **23** If less than one day
73 **7** **22** hr. min.

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

10. Usual occupation **Nil**

11. Industry or business.....

12. Name **Lucius Hayes**

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

14. Maiden name **Caroline ?**

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

16. (a) Informant **City Infirmiry Records**

(b) Address **5800 Arsenal St.**

17. (a) **BURIAL** (b) Date thereof **DEC 31-1946**
(Burial, cremation, or other disposal) (Month) (Day) (Year)

(c) Place: burial or cremation **SUN SET BURIAL PK.**

18. (a) Signature of funeral director **E. J. Schner**

(b) Address **3125 Lafayette Av.**

19. (a) **DEC 31 1946** (b) **J. F. Breda**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec, 29** day.....
year **1946** hour **6** minute **A** M.

21. I hereby certify that I attended the deceased from **12/5**
1946 to **12/29**, 19 **46**
that I last saw her alive on **12/29**, 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized arteriosclerosis**
Duration **1946#**
Due to **Old hemiplegia contraction 1946#**

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)
(c) Means of injury.....

23. Signature **Palmer P. Breda** (M. D. or other)
Address **5800 Arsenal St** Date signed **12/29**

MOTHER FATHER

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 Joseph B. Vallin
Licensed Embalmer No. 4014
P. O. Address St Louis 4, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.