

FILED AUG 25 1948
Registration District No. 449

Primary Registration District No. 4484

State File No. _____
Registrar's No. 13

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Green City Town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
At home in Green City
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 84 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Green City Town
(If outside city or town limits, write "RURAL")
(d) Street No. No street number
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16
year 1948 hour 3 minute 15 A.M.
21. I hereby certify that I attended the deceased from August
13, 1948, to _____, 1948;
that I last saw him alive on August 13, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death: Colonial Thrombosis
Duration: 2 days

Due to _____
Due to _____

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 2
23. Signature R.D. Smith M.D. (M. D. or other) M.D.
Address Green City, Mo. Date signed Aug 17, 48

3. (a) PRINT FULL NAME William Thomas Kent

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

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

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

7. Birth date of deceased June 6 1859
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 10
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Harrison Kent
13. Birthplace Pa.
(City, town, or county) (State or foreign country)

14. Maiden name Jane Phillips
15. Birthplace Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Martin
(b) Address Green City, Mo.

17. (a) Burial (b) Date thereof Aug. 17, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hawkeye Cem

18. (a) Signature of funeral director Glenn E. Fent
(b) Address Green City, Mo.

19. (a) August 21-48 (b) Faura Collett
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 8148-1479
Date Filed AUG 23 1948

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.