

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

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#37730

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31163**
Registrar's No. **8249**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Mo.**
(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: **St. Louis City Hospital—Max C. Starkloff**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0** (Specify whether
in this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000 17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **2432 Fall Ave.** (If rural, give location)
Memorial
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM KENT**
3. (b) If veteran, name war _____
3. (c) Social Security No. **477-07-7017**

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Alice** 6. (c) Age of husband or wife if alive **38** years
7. Birth date of deceased **10 10 1903**
(Month) (Day) (Year)

8. AGE: Years **44** Months **11** Days **10** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Maintenance Man**

11. Industry or business _____

MOTHER FATHER { 12. Name **George Kent** **4**

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

14. Maiden name **Blanche Walker**

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

16. (a) Informant **Alice Kent**

(b) Address **2432 Fall Ave.**

17. (a) **burial** (b) Date thereof **9 22 48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **A. A. Kron Und. Co.**

(b) Address **2707 N. Grand**

19. (a) **SEP 21 1948** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **20th**
year **1948** hour **4** minute **28 A.M.**

21. I hereby certify that I attended the deceased from **9/7/48**
_____, 19____, to **Sept. 20th**, 19**48**;
that I last saw h **im** alive on **Sept. 20th**, 19**48**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Glioblastoma** Duration _____

of Frontal lobe of Brain 3 yrs

Due to _____
Due to **JH**

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

Major findings:
Of operations _____

Of autopsy **Same**

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? **0**

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

23. Signature **William M. Lander M.D.** (M.D. or other) _____

Address **1515 Lafayette 9/20/48** signed _____

Embalmer's separate Cert. filed

SEP 21 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.....

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, fact should be so stated above.