

FILED JUL 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19346

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. #221 Registrar's No. #4

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Mound City.</u>		c. LENGTH OF STAY (in this place) <u>50 yrs.</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mound City.</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>Mound City, State St</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Marcus</u>	b. (Middle) <u>Russel</u>	c. (Last) <u>Lent.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 25 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 24th, 1894</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Blue Rapids Kansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Abraham Lent</u>	13b. MOTHER'S MAIDEN NAME <u>Mary. Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Goldie May Lent.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>500-07-7413</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Goldie May Lent. Mound City, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary carcinoma</u>		
	ANTECEDENT CAUSES <u>B gall bladder</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>155X</u>

19a. DATE OF OPERATION <u>Apr 1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>carcinoma gall bladder</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 30 1949, to 6-25 1949, that I last saw the deceased alive on 6-24 1949 and that death occurred 3:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>F E Hogan</u> (Degree or title)	23b. ADDRESS <u>Mound City, Mo</u>	23c. DATE SIGNED <u>6-25-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/26/49.</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery.</u>	24d. LOCATION (City, town, or county) (State) <u>Mound City. Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>6-21-49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Mound City, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 28 1950



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by _____

Body was not embalmed.

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *W. H. Crawford*

Licensed Embalmer No. *1824*

P. O. Address *Maumond 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.