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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19330

FILED JUN 12 1953

State File No. 5210

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5210

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (In this place) 7 days	c. CITY OR TOWN KIRKWOOD 69	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 700 CREAMBROOK DR. 4693	

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) Elizabeth c. (Last) Dent	4. DATE OF DEATH (Month) (Day) (Year) May 23, 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT 3-1878	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Mo	12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME JAMES RAYFIELD	13b. MOTHER'S MAIDEN NAME UNKNOWN	13c. NAME OF HUSBAND OR WIFE GEO. B DENT
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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.	INFORMANT'S SIGNATURE OR NAME Geo R Dent 700 Creambrook Dr	ADDRESS 700 Creambrook Dr
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure		
	ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic heart disease with decompensation DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cancer of ovary			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from 5/16, 1953, to 5/23, 1953, that I last saw the deceased alive on 5/23, 1953, and that death occurred at 4:35 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. M. D. O.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 5/23/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5/23/53	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem	24d. LOCATION (City, town, or county) (State) St. Louis
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 25 1953	25. EMBALMER'S SIGNATURE J. Carl Smith	ADDRESS 5165 Delmar
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(Licensed Embalmer, State of Missouri on Reverse Side)

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

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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ronald O. Johnson*

Licensed Embalmer No. *2*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.