

FILED FEB 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1829**

BIRTH NO. _____ REG. DIST. NO. **172** PRIMARY REG. DIST. NO. **7270** Registrar's No. **9- (1957)**

1. PLACE OF DEATH
a. COUNTY **Lafayette**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY **Lafayette**

b. CITY OR TOWN **Dover** c. LENGTH OF STAY (in this place) _____

c. CITY OR TOWN **Dover** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **3 miles Town of Dover**

e. STREET ADDRESS (If rural, give location) **3 miles east of Dover**

3. NAME OF DECEASED
a. (First) **WALTER** b. (Middle) **E.** c. (Last) **TRENT**

4. DATE OF DEATH (Month) (Day) (Year) **January 16, 1957**

5. SEX **Male** 6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **August 4, 1883**

9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) **73 5 12**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farmer**

10b. KIND OF BUSINESS OR INDUSTRY **Farming**

11. BIRTHPLACE (City and State or Foreign Country) **Dover, Missouri.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Walter S. Trent**

13b. MOTHER'S MAIDEN NAME **Roberta Starke**

14. NAME OF HUSBAND OR WIFE **Malinda C. Schowe**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **G.L. Trent, Lexington, Missouri**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis
ANTECEDENT CAUSES
Morbid 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.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH **Sudden**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) **Lexington, Mo**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **5:00P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **J. W. Wardlaw**

23b. ADDRESS **Lexington, Mo**

23c. DATE SIGNED **1/21/57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **January 19, 1957**

24c. NAME OF CEMETERY OR CREMATORY **Dover**

24d. LOCATION (City, town, or county) (State) **Dover, Missouri.**

DATE REC'D BY LOCAL REG. **Jan 25 - 57** REGISTRAR'S SIGNATURE **Clayton W. Landon**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Forest F. Temple, Lexington, Missouri**

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

