

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009891

STATE FILE NUMBER

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1131

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Length of stay in hospital 38 yrs. 10 mos. 22 days	d. STREET ADDRESS (If outside, give location) 523 Grand Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle H. Last DENTON			4. DATE OF DEATH Month Mar Day 2 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-18-88	9. AGE (In years of birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY 7 TH WALNUT Grove, Chazy, N. Y.		11. BIRTHPLACE (City and state or country) USA	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME B. H. Denton		13b. MOTHER'S MAIDEN NAME Lena Perry	
14. NAME OF HUSBAND OR WIFE MILDRED DENTON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 496-01-6329	
17. INFORMANT VA Hospital Records, K. C. Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO (b) _____ DUE TO (c) Jaundice PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 58 1/2	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION VA		20g. COUNTY		20h. STATE	
21. I attended the deceased from Dec 18, 1956 to Mar 2, 1958 and attended to the Death occurred at 8:10 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Joseph H. Sloss M.D.		22b. ADDRESS VA Hospital, K. C. Mo.	
22c. DATE SIGNED 3-2-58		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar 4 1958	
23c. NAME OF CEMETERY OR CREMATORY CONCORD NEW HAMPSHIRE		23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR DW. NEWCOMER'S SONS 1331 BRUSH CREEK RANAS CITY MO	
25. DATE RECD. BY LOCAL REG. 3-3-58		26. REGISTRAR'S SIGNATURE neva munsell		27. REGISTRAR'S SIGNATURE	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Joseph H. Sloss

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 *James W. Person*

Licensed Embalmer No. *4889*

P. O. Address *D. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.