

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026234  
STATE FILE NUMBER

AMENDED

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 41

FILED AUG 3 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Phelps</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. James</u>		Length of stay in 1b <u>16 yrs</u>	c. CITY OR TOWN <u>ST. James</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Soldiers Home Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>H.</u> Last <u>KENT</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>'61</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1893</u>	9. AGE (last birthday) <u>68</u>	10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (City and state or country) <u>INDIANNA -</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Thomas Kent</u>		13b. MOTHER'S MAIDEN NAME <u>LAURA THUSAL</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Kent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes U.S.A.</u>			17. INFORMANT <u>Mrs Grace Kent - ST. James, MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Prostate</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year _____					
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		COUNTY _____ STATE _____
21. I attended the deceased from <u>May 20th 1960</u> to <u>July 29th, 1961</u> and last saw him alive on <u>July 29th, 1961</u> Death occurred at <u>4.05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>R. Grosskreutz MD</u>			22b. ADDRESS <u>St. James, MO</u>		22c. DATE SIGNED <u>8-1-61</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-1-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Soldiers Home Cem.</u>		23d. LOCATION (City, town, or county) <u>ST. James, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Orap E. Lieblidow - St James, MO</u>			25. DATE RECD. BY LOCAL REG. <u>8-1-1961</u>	26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>	

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

(Licensed Embalmer's Statement on Reverse Side)

AUG 8 1961

NOV 9 1961

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 me, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Craig E. Licklider

Licensed Embalmer No. 3544

P. O. Address St James 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.