

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028451

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3971

FILED AUG 6 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY, MISSOURI</b> Length of stay in <b>2 days</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> c. CITY OR TOWN <b>SPRINGFIELD, MO.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>951 S Delaware</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ELMER LEWIS KENT</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>July 13, 1963</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>W.</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/30/95</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RETIRED</b>	
<b>13a. FATHER'S NAME</b> <b>LEWIS J. KENT</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>FLORENCE PETTJOHN</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 5/5/17 to 12/11/18</b>		<b>17. INFORMANT</b> Mrs Bess Kent Address <b>951 S Delaware VA HOSPITAL RECORDS - Springfield, Mo.</b>	

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RETIRED</b>	
<b>11. BIRTHPLACE</b> (City and state or country) <b>ST LOUIS, MO.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>LEWIS J. KENT</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>FLORENCE PETTJOHN</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>BESS KENT</b>		<b>17. INFORMANT</b> Mrs Bess Kent Address <b>951 S Delaware VA HOSPITAL RECORDS - Springfield, Mo.</b>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION OF RIGHT CERIBELLAS HEMISPHERE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>THROMBOSIS OF POST INF. CEREBELLAS ARTERY</b> DUE TO (c) <b>ATHEROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH	
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	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	

**21. VA** attended the deceased from 7/11/63 to 7/13/63 and last saw him 7/13/63  
 Death occurred at 2:20 AM 7/13/63 m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Type or title) <i>James M. Flynn M.D.</i>	<b>22b. ADDRESS</b> <b>VAH-KANSAS CITY, MO.</b>	<b>22c. DATE SIGNED</b> <b>7/13/63</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>7-15-63</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>Springfield Mo.</b>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Sherman Scharph - Springfield, Mo.</b>		<b>25. DATE REC'D. BY LOCAL REG.</b> <b>7-15-63</b>	<b>26. REGISTRARS SIGNATURE</b> <i>Ruth Long</i>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 1  
 2 03972  
 3  
 4 0  
 5 1  
 6  
 7 0  
 8 1  
 9 9332X  
 10  
 11  
 12 76-0  
 13  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF **James M. Flynn** MEDICAL CERTIFICATION DOCUMENT

**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 Forest D. Coldman

Licensed Embalmer No. 4714

P. O. Address K.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.