S. No. 2
1—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 15 1947
Registration District No. 274

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32038
Primary Registration District No. 3052
Registrar's No. 313

1. PLACE OF DEATH:
(a) County: Pettis
(b) City or town: Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bothwell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 da.
In this community: 42 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Pettis
(c) City or town: Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No.: 814 State Fair Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Walter Scott Dent
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: November 19, 1856 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
90	9	17	hr. min.

9. Birthplace: Bismarck (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Agent Mo.Pac.R.R.

MOTHER FATHER
12. Name: William Dent
13. Birthplace: (City, town, or county) Tenn. (State or foreign country)
14. Maiden name: Sarah Sherrill
15. Birthplace: Bismarck (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Paul Dent
(b) Address: Sedalia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Crown Hill
18. (a) Signature of funeral director: Geo Dillard
(b) Address: Sedalia mo
19. (a) 9/20/47 (Date received local registrar) (b) Betty Yeager (Registrar's signature) Deputy

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1947 hour Nine o'c minute 15 P.M.

21. I hereby certify that I attended the deceased from September, 15, 1947, to September, 17, 1947, that I last saw him alive on September, 17, 1947, P/M; and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Anuria, complete	Acute.
xxx	
xxx	
Due to: Nephritis, congestive,	Acute.
xxx	
Due to: xxx	
xxx	
Other conditions: No. (Include pregnancy within 3 months of death)	
xxx	

Major findings: Of operations: No operation.
xxx
Of autopsy: No autopsy,
xxx

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): xxx
(b) Date of occurrence: xxx
(c) Where did injury occur? No injury. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
xxx (Specify type of place)
While at work? xxx (e) Means of injury: xxx

23. Signature: C. B. Braden (M. D.) M.D.
Address: 112 West 4t, Sedalia, Mo. Date signed 9-19-47

RECEIVED
District Health Officer No. 8,
District File Number .....
Date Filed 10-13-47

STATEMENT BY LICENSED EMBALMER

OCT 14 1947

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....,
working under my personal supervision.

Signed John G. Carlton

Licensed Embalmer No. 4387

P. O. Address Sedalia 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 this body is not embalmed, fact should be so stated above.