

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007835

FILED VS MAR 8 1960

Registration District No. 316 Primary Registration District No. — Registrar's No. 85 STATE FILE NUMBER

DED

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>                                                                                                                                                                                                                                                                                         |                                        |                                                                                                                                                             |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b> |                                                                            |                                                                                                                                                                                 |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Francois Township</b>                                                                                                                                                                                                                                          |                                        |                                                                                                                                                             | Length of stay in 1b                                                                 |                                                                                                                                                 | c. CITY OR TOWN <b>Farmington</b>                                          |                                                                                                                                                                                 | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>RFD#3, Farmington</b>                                                                                                                                                                                                                                    |                                        |                                                                                                                                                             | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                                                                                 | d. STREET ADDRESS (If outside, give location)<br><b>Rural Route # 3</b>    |                                                                                                                                                                                 | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Kate</b> Middle <b>E.</b> Last <b>Brent</b>                                                                                                                                                                                                                                             |                                        |                                                                                                                                                             |                                                                                      | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>29</b> Year <b>1960</b>                                                                        |                                                                            |                                                                                                                                                                                 |                                                                                       |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 24, 1879</b>                                            |                                                                                                                                                 | 9. AGE (last birthday)<br><b>80</b>                                        | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HR<br>Hours Min.                                                                                                                  |                                                                                       |
| 10a. USUAL OCCUPATION (Give kind of work done<br>if deceased was ever employed)<br><b>Retired School teacher</b>                                                                                                                                                                                                                           |                                        |                                                                                                                                                             | 10b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                                                 | 11. BIRTHPLACE (City and state or country)<br><b>St. Francois Co., Mo.</b> |                                                                                                                                                                                 | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                             |
| 13a. FATHER'S NAME<br><b>Elbert Thomas Brent</b>                                                                                                                                                                                                                                                                                           |                                        |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><b>Lillian Scott</b>                                    |                                                                                                                                                 |                                                                            | 14. NAME OF HUSBAND OR WIFE                                                                                                                                                     |                                                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, none, unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                    |                                        |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>None</b>                                               |                                                                                                                                                 | 17. INFORMANT<br><b>Lillian Brent</b> Address <b>St. Louis, Missouri</b>   |                                                                                                                                                                                 |                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b><br>DUE TO (b) <b>Hypertensive heart disease -</b><br>DUE TO (c) <b>—</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                 |                                                                            | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs -</b><br><b>3 yrs -</b>                                                                                                           |                                                                                       |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 <b>Nov. 1957</b> to <b>Feb. 29 1960</b> and last saw her alive on <b>Feb. 27, 1960</b><br>Death occurred at <b>5:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                           |                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                 |                                                                            |                                                                                                                                                                                 |                                                                                       |
| 22a. SIGNATURE<br><b>R. H. [Signature]</b> (Degree or title) <b>Dr.</b>                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                             |                                                                                      | 22b. ADDRESS<br><b>Farmington Mo.</b>                                                                                                           |                                                                            | 22c. DATE SIGNED<br><b>3-3-60</b> (State)                                                                                                                                       |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                 |                                        | 23b. DATE<br><b>3/3/60</b>                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>K of P Cemetery</b>                         |                                                                                                                                                 | 23d. LOCATION (City, town, or county)<br><b>Farmington Missouri</b>        |                                                                                                                                                                                 |                                                                                       |
| 24. FUNERAL DIRECTOR<br><b>Miller Funeral Home Farmington, Mo.</b>                                                                                                                                                                                                                                                                         |                                        |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><b>Mar. 3, 1960</b>                                  |                                                                                                                                                 | 26. REGISTRAR'S SIGNATURE<br><b>Esther Rudloff</b>                         |                                                                                                                                                                                 |                                                                                       |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Paul K. Dwyer

Licensed Embalmer No. 4120

P. O. Address Farmington

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.