

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1237

State File No. ....

FILED JAN 31 1946

Registration District No. *49*

Primary Registration District No. *1002*

Registrar's No. *157*

1. PLACE OF DEATH

(a) County *Jackson*

(b) City or town *Russell City*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
*5411 E 28*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: *In hospital or institution*

In this community *35 yrs.*  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Jackson 48*

(c) City or town *Russell City 3*  
(If outside city or town limits, write "RURAL")

(d) Street No. *5411 E-28 St 8*  
(If rural, give location)

(e) Citizen of foreign country? *0* (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME *Agnes Belle Cantrell*

3. (b) If veteran, name war *no*

3. (c) Social Security No. *none*

4. Sex *Fe*

5. Color or race *wh*

6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Carol A. Cantrell*

6. (c) Age of husband or wife if alive *80* years

7. Birth date of deceased *July 26 1860*  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *11* year *1946* hour *1* minute *30* M.

21. I hereby certify that I attended the deceased from *only on*  
*Jan 10* 19*46*  
that I last saw her alive on *Jan 10* 19*46*  
and that death occurred on the date and hour stated above.

Immediate cause of death *asthma*

Duration  *yrs*

8. AGE: Years Months Days If less than one day

*85 5 15* hr. min.

9. Birthplace *Harrison Co Ind 1*  
(City, town, or county) (State or foreign country)

10. Usual occupation *at home*

11. Industry or business

12. Name *William H. Kentner*

13. Birthplace *Louisville Ky 1*  
(City, town, or county) (State or foreign country)

14. Maiden name *Amelia Binkley*

15. Birthplace *Harrison Co Ind 1*  
(City, town, or county) (State or foreign country)

16. (a) Informant *Arthur B. Ellis*

(b) Address *5411 E 28*

17. (a) Burial (Burial, cremation, or removal) *Memorial PK*

(b) Date thereof *Jan 12-1946*  
(Month) (Day) (Year)

18. (a) Signature of funeral director *Wm C. R. Foster*

(b) Address *918 Brooklyn*

19. (a) *1-11-46* (Date received local registrar)

(b) *M. H. Holman* (Registrar's signature)

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

*Myocarditis Chronic*

Major findings: Of operations.....

Of autopsy *932*

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).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (County) (State).....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work? (Specify type of place) (c) Means of injury.....

23. Signature *Edwin H. Thomas* (M. D. or other).....

Address *10729 W. Brady St. Mo* (City, town, or county) (State).....

*1-11-46*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Part of body

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Cortland M. Munn*

Licensed Embalmer No. *3414*

P. O. Address..... *918 Brooklyn*  
*K. M. Munn*

**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.**