

No. 2  
17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **11942**

APR 9 1941

Registration District No. **78x**

Primary Registration District No. **101**

Registrar's No. **648**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton

(c) Name of hospital or institution: St. Louis County Hospital

(d) Length of stay: In hospital or institution 2 days

In this community life

3. (a) PRINT FULL NAME Leo Sargent

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 5. Color or race colored

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 12 1940

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>1</u>	<u>9</u>	hr. _____ min.

9. Birthplace Clayton Mo.

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name James Smith

13. Birthplace unknown unknown

14. Maiden name Lucille Sargent

15. Birthplace Lilbourn Mo.

16. (a) Informant Mr. Sargent (godfather)

(b) Address 1 Kinloch

17. (a) \_\_\_\_\_ (b) Date thereof 3-25-41

(c) Place: burial or cremation Hughes Park

18. (a) Signature of funeral director W. H. Brock

(b) Address 1 Kinloch

19. (a) WAR 25 1941 (b) T. R. Meyer

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town S. Kinloch Park

(d) Street No. 10 Boyd ave, and Carson Rd.

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21

year 1941 hour 1 minute :20 P.M.

21. I hereby certify that I attended the deceased from 3-19-41

to 3-21-41

that I last saw him alive on 3-21-41

and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis meningitis *3 weeks*

Due to: Pulmonary tuberculosis *2 1/2 Mo*

Due to: 13 1/2

Other conditions: \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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? \_\_\_\_\_

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

While at work? \_\_\_\_\_ (Specify type of place)

Means of injury \_\_\_\_\_

23. Signature B. H. Stuchman (M. D. or other) D

Address 10 Boyd Date signed \_\_\_\_\_

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

66  
22  
3

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**