

FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9153

State File No.

| | | | | | | | | | | | |
|--|--------------------------|--|---|---|---------------------|---|---|--|-------------------------|---|----------------------------|
| BIRTH NO. | | REG. DIST. NO. <u>200</u> | | PRIMARY REG. DIST. NO. <u>3041</u> | | Registrar's No. <u>32</u> | | | | | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| a. COUNTY <u>MACON</u> | | b. CITY (If outside corporate limits, write RURAL and give township) <u>MACON</u> | | a. STATE <u>Mo.</u> | | b. COUNTY <u>MACON MO</u> | | | | | |
| c. LENGTH OF STAY (in this place) <u>5 yrs</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>MACON</u> | | d. STREET ADDRESS (If rural, give location) <u>329 N. Rollins</u> | | 3 2 | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>329 N. Rollins</u> | | | | d. STREET ADDRESS (If rural, give location) <u>329 N. Rollins</u> | | | | | | | |
| 3. NAME OF DECEASED | | | 4. DATE OF DEATH | | | 5. SEX | | | | | |
| a. (First) <u>Arthur</u> | b. (Middle) <u>H.</u> | c. (Last) <u>Sargent</u> | Month <u>Feb.</u> | Day <u>25</u> | Year <u>1949</u> | Male <input checked="" type="checkbox"/> | Female <input type="checkbox"/> | | | | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Jan. 16, 1880</u> | | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hour | IF UNDER 1 HRS. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Presbyterian Church</u> | | | 11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13a. FATHER'S NAME <u>Edgar Sargent</u> | | | 13b. MOTHER'S MAIDEN NAME <u>✓</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Margaurite Sargent</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>✓</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. A.H. Sargent</u> | | | | ADDRESS <u>MACON, MO.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u> | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> | | | | ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocarditis</u> | | | | 4201 | | | | | | See up. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>44</u> , to <u>Feb 25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>49</u> , and that death occurred at <u>3:29 a. m.</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Howard Miller MD</u> | | | | 23b. ADDRESS <u>MACON MO</u> | | | | 23c. DATE SIGNED <u>3/1/49</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>2/27/1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Higginville Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Higginville, MO.</u> | | | | | |
| DATE REC'D BY LOCAL REG. <u>3-10-49</u> | | REGISTRAR'S SIGNATURE <u>Weth McNeely</u> | | | 185 | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Skinner</u> | | | | ADDRESS <u>MACON MO</u> |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No.

District File Number 349

Date Filed MAR-16-1949

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
Student Embalmer

Signed Alvin Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon

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.