

FILED SEP 22 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31896

State File No. \_\_\_\_\_  
Registrar's No. **7669**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b> <b>2109</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4005a Greer Ave.</b>		d. STREET ADDRESS (If rural, give location) <b>16 4005a Greer Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>SAMUEL</b> b. (Middle) <b>J...</b> c. (Last) <b>SARGENT Sr.</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 9 1950</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Sept. 10 1871</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>			12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME <b>James Sargent</b>		13b. MOTHER'S MAIDEN NAME <b>Bridget Doyle</b>		14. NAME OF HUSBAND OR WIFE <b>Julia Sargent</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Julia Sargent 4005a Greer Ave.</b>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Internal Hemorrhage, Intestinal</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Arterio Sclerosis</b>		10 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <b>Frailty</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H/OX</b>	

22. I hereby certify that I attended the deceased from           , 1930, to Sept 9, 1950, that I last saw the deceased alive on Sept 9, 1930, and that death occurred at 10:20am., from the causes and on the date stated above.

23a. SIGNATURE <b>Am Krace MD</b>		(Degree or title) <b>D</b>		23b. ADDRESS <b>24162 Grand</b>	
23c. DATE SIGNED <b>9/11/50</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9/12/50</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>			

DATE REC'D BY LOCAL REG. <b>SEP 11 1950</b>		REGISTRAR'S SIGNATURE <b>L.P. Kacater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan Funeral Dir.</b>	
				ADDRESS <b>2849N. Euclid</b>	

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

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

*Gustav W. Dittler*

Licensed Embalmer No. *4329*

P. O. Address *St Louis 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.