

If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state  
 DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

37559

1927  
 1928  
 JAN 2

1 PLACE OF DEATH

County Clark  
 Township Grant  
 Village .....  
 or  
 City ..... (NO ..... St.; ..... Ward)

Registration District No. 192 File No. ....

Primary Registration District No. 5270 Registered No. ....

2 FULL NAME

Helen Madine Sargeant

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (If more than one word)
6 DATE OF BIRTH <u>July 12 1921</u> (Month) (Day) (Year)		
7 AGE <u>5 5 4</u> yrs. mos. ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Clark Co., Mo</u>		
PARENTS	10 NAME OF FATHER <u>Oliver Sargeant</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Iowa</u>	
	12 MAIDEN NAME OF MOTHER <u>Essie Rhyme</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Wisconsin</u>	

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Dec. 16 - 1926  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 16, 1926, to Jan 16, 1926, that I last saw her alive on Jan 16, 1926, and that death occurred, on the date stated above, at 7:12 PM

The CAUSE OF DEATH\* was as follows:  
Stroke was caused by  
to death on 16 Jan 26  
5 1/2 hours after the onset  
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)  
(Duration).....yrs.....mos.....ds.

(Signed) M. J. Ken M. D.  
Dec 16 1926 (Address) Farmington Ia.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver Sargeant  
 (Address) Farmington Ia.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?  
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL  
Wash Cemetery

DATE OF BURIAL  
Dec 18 - 1926

Filed 12/17, 1926  
J. L. Howell  
 Registrar

20 UNDERTAKER  
W. C. Lutz  
 ADDRESS  
Farmington Ia.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
County Frank Registration District No. 192 File No. \_\_\_\_\_  
Township Grant Primary Registration District No. 9273 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Helen Nadine Sargent  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1936

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Burned to death, only lived 5 1/2 hrs after burn. Certify & signed for flow.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. da.

MISSOURI

18. WAS DISEASE CONTRACTED AT PLACE OF DEATH? \_\_\_\_\_  
19. OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
20. AN AUTOPSY? \_\_\_\_\_

Please state whether a burning building was involved or not. Please sign and return. no

SUPP

11. PLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED Dec 21 1936 J. L. McNeill REGISTRAR

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D. \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19____

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state EXACTLY. CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION should be given. THIS INFORMATION MUST BE WRITTEN ON THIS SUPPLEMENTARY. USE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

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