

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

Do not use this space.

26521

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... **St. Louis, Mo.** (No.)

Sanitarium

File No.....

Registered No. **7787**

St. Ward)

2. FULL NAME

Augusta Sargent

(a) Residence. No. **4729 Minnesota** St. **13** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **44** yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 29, 1856**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 **29**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housework**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... **Unknown**
(STATE OR COUNTRY) **Germany**

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) **Germany**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) **Germany**

14. INFORMANT **William T. Gutter, M.D.**
(Address) **5400 Arsenal St.**

15. FILED **11 28 1929** **May C. [Signature]** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7/27** 19**29**

17. I HEREBY CERTIFY, That I attended deceased from **July 1, 1928** to **July 27, 1929** that I last saw her alive on **July 27, 1929**, and that death occurred, on the date stated above, at **2:20** P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis

97 **9/18** (duration) **14** yrs. **8** mos. **1** ds. +

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH **Unknown**

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **William T. Gutter**, M. D.

7/27, 1929 (Address) **5400 Arsenal St**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
New Set Burial Park **July 30, 1929**

20. UNDERTAKER ADDRESS
Chas. Curtis Brown **2906**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10835

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100