

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

Do not use this space.

OCT 5 1936

791

35860

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No. **1003**
 City St. Louis, Mo. (No. CITY HOSPITAL NO. 2) St. Ward)

2. FULL NAME Robert Sargent

(a) Residence, No. 3138a Sheridan st., 21 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 17, 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 8 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

FATHER 13. NAME Albert Sargent

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER 15. MAIDEN NAME Margaret ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Walter May Sheridan
2945 Lawton Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE Sept. 16, 1936

19. UNDERTAKER (ADDRESS) Ira Hamilton
Dept. of Health

20. FILED SEP 15 1936 J. A. Brebeck
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 5, 1936

22. I HEREBY CERTIFY, That I attended deceased from 3-14- 1936, to 9-5- 1936

I last saw him alive on 9-5- 1936 Death is said to have occurred on the date stated above, at 2:55 A. M.

The principal cause of death and related causes of importance were as follows:

Chronic Myelogenous Leukemia Date of onset 3-14-
36

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?.....
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....
 (Signed) A. L. Lewis M. D.

(Address) City Hospital #2

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.

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