

No. 2
4-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43333

State File No. _____

FILE

Registration District No. 624

Primary Registration District No. 4075

Registrar's No. 22

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

1. PLACE OF DEATH:
(a) County NODAWAY
(b) City or town HOPKINS
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 60 yrs 7 months (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME DANA AMOS SARGENT

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased MAY 18 1854
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace ONTARIO IND.
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor of Medicine

11. Industry or business _____

12. Name AMOS DAVIS SARGENT

13. Birthplace Hudson New Hampshire
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH WORTHING

15. Birthplace NEW HAMPTON New Hampshire
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Sargent
(b) Address Hopkins Mo

17. (a) BURIAL (b) Date thereof Dec. 19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOPKINS, MO

18. (a) Signature of funeral director Stanley Swanson
(b) Address Hopkins Mo
19. (a) 12/19/40 (b) Dr. Taylor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County NODAWAY
(c) City or town HOPKINS
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1940 hour 9 minute 45 P M.

21. I hereby certify that I attended the deceased from 12/13/40
_____ 19____, to 12/17 19 40
that I last saw him alive on 12/17/40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Broncho-pneumonia

Due to Senility Duration Unknown

Due to Fractured left hip 4 days

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy none

Duration
3 days
Unknown
4 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 12/13/40

(c) Where did injury occur? Hopkins holding ms
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
55 in home
While at work? no (Specify type of place) (e) Means of injury fall

23. Signature P W Taylor (M. D. or other) M.D.
Address Hopkins Mo Date signed 12/19/40

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 *myself*

....., Registered Apprentice No.
working under my personal supervision.

Signed *Stanley Swanson*

Licensed Embalmer No. *3963*

P.O. Address *Hopkinton, Mass.*

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.