

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35540

State File No. 8934

318

1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		_____	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3801 a Parnell Street				d. STREET ADDRESS (If rural, give location) 20- 3801 a Parnell Street			
3. NAME OF DECEASED (Type or Print) a. (First) VIVAN		b. (Middle) SARGENT		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) Oct 16, 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 5, 1900	
9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) Sullivan, Kentucky /	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Lovan		13b. MOTHER'S MAIDEN NAME Grady Martin		14. NAME OF HUSBAND OR WIFE Joe Sargent			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Joe Sargent, 3801 a Parnell Street			
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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Chronic Gastritis				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) 971		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201				22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:05 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE [Signature] (Degree or title) _____		23b. ADDRESS 1300 Clark Ave		23c. DATE SIGNED 10/18/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 18, 1949		24c. NAME OF CEMETERY OR CREMATORY White Oak Cemetery		24d. LOCATION (City, town, or county) Providence Kentucky	
DATE REC'D BY LOCAL REG. OCT 18 1949		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home, 1167 Hamilton Ave			

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 Blair R. Padwell

Licensed Embalmer No. 4077

P. O. Address _____

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.