

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24315

State File No.

FILED AUG 15 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6446**

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 township) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 4576 Chouteau Ave.	
3. NAME OF DECEASED (Type or Print) JOSEPH W. SARGENT		a. (First)	b. (Middle)
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 14, 1894	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Engineer	
11. BIRTHPLACE (City and State or Foreign Country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME James Sargent		13b. MOTHER'S MAIDEN NAME Susan Schneider	
14. NAME OF HUSBAND OR WIFE Marion		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 240-03-3898		17. INFORMANT'S SIGNATURE OR NAME Mrs. Marion Sargent	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of hypopharynx and larynx (primary site) DUE TO (c) non-metastatic II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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)	
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?		22. I hereby certify that I attended the deceased from February 19, 55 , to July 25, 19 55 , that I last saw the deceased alive on July 25 , 19 55 , and that death occurred at 8:05p m. , from the causes and on the day stated above.	
23a. SIGNATURE (Degree or title) FR Bradley M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 7/26/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 7-28-55		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
DATE REC'D BY LOCAL REG. JUL 26 1955		ADDRESS 4700 Washington Blvd.	

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.....
Signature of Student Embalmer

Signed *J. W. M. Bentler*.....
Licensed Embalmer No. *365*.....
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. ...
If this body is not embalmed, fact should be so stated above.