

Health, Welfare, Public Services

300
1-56
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE HEALTH DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26834

STATE FILE NUMBER

FILED AUG 5 1957

Registration District No. 317

Primary Registration District No. 542

Registrar's No. 1779

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Ferguson 4119		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 246 St. Louis Ave. 10 yrs				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 246 St. Louis Ave.	
3. NAME OF DECEASED (Type or print)		First Homer		Middle Frank		Last Argent	
4. DATE OF DEATH		Month July		Day 13,		Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 28, 1900	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Corr. Box Co.		11. BIRTHPLACE (City and state or country) Wright City, Mo.	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME George A. Argent				14. MOTHER'S MAIDEN NAME Minnie Thurman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-05-8207		17. INFORMANT Address Ione E. Argent, 246 St. Louis Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of Rectum with Metastases to lung DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 15 min. 18 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 154X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1954 to Present and last saw him alive on 6/20/57 . Death occurred at 8:15 m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE [Signature] (Degree or title)				22b. ADDRESS Folorissant No 6		22c. DATE SIGNED 7/13/57 (State)	
23a. BURIAL, CREMATION, etc. (Specify)		23b. DATE 7-16-57		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) Normandy, Mo.	
24. FUNERAL DIRECTOR ADDRESS White Chapel, Ferguson, Mo.				25. DATE RECD. BY LOCAL REG. 7/15/57		26. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

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 Eduardo Povea

Licensed Embalmer No. 344

P. O. Address San Diego

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.