THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003340

STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 756

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. John's Hos. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2349A St. Louis Ave. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Patrick M. Nugent

4. DATE OF DEATH: Month Jan. Day 21 Year 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20-1959
9. AGE (In years last birthday): IF UNDER 1 YEAR Months — Days 1 — IF UNDER 24 HRS. Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.,
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Patrick M. Nugent Jr.
13b. MOTHER'S MAIDEN NAME: Christine Kyle
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: P. M. Nugent — Address: 2349 A St. Louis Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Birth Injury. — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage
DUE TO (c) 760.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan 20 to Jan 21 and last saw her/him alive on Jan 20
Death occurred at 4:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. Earl Smith (Degree or title) M.D.
22b. ADDRESS: 8760 Riverview
22c. DATE SIGNED: Jan 23-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 23-59
23c. NAME OF CEMETERY OR CREMATORY: Friedens Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.,

24. FUNERAL DIRECTOR — ADDRESS: Leidner Un. Co. 2223 St. Louis Ave.
25. DATE REC'D. BY LOCAL REG.: JAN 23 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. M. J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Not Embalmed

Student .....
Signature of Student Embalmer

Signed W. Rodigast

Licensed Embalmer No.....

P. O. Address.....

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