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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 29882

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3864

**1. PLACE OF DEATH:**
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week (Specify whether
In this community 31 years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Jackson 48
(c) City or town Grandview 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MRS. RUBY V SARGENT

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female | 5. Color or race White | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lee Sargent

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Jan 21 1897 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 7 | 27 | hr. min. |

9. Birthplace Fort Scott Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name R. C. Sivey
13. Birthplace No record 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace No record 9 (City, town, or county) (State or foreign country)

16. (a) Informant Lee Sargent
(b) Address Grandview Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/18/45 (Month) (Day) (Year)
(c) Place: burial or cremation Fort Scott Kansas

18. (a) Signature of funeral director Burk & Robin Co.
(b) Address 20 West Linwood

19. (a) 9-18-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 18th day Sept year 1945 hour 12.40 minute P M.

21. I hereby certify that I attended the deceased from Pathologist to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Acute pulmonary | |
| Due to infarction | |
| Due to Hypertrophy of Heart | |
| Other conditions (Include pregnancy within 3 months of death) Hypertension 2 | |
| Major findings: Of operations 9 5C | |
| Of autopsy See Above | |

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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature A. E. Fisher M.D. (M. D. or Coroner)
Address 2800 Main Date signed 9/19/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Charles M Quirk

Licensed Embalmer No. 3774

P. O. Address Kansas City Mo

**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.**