MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16861

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4813

City St Louis Mo (No. 3501 Washington Ave St. ..... Ward)

2. FULL NAME William S. P. Thurman

(a) Residence. No. 3501 Washington St., 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Thurman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 1851

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	5	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Medicine Manufacture

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Jeptha Thurman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

14. INFORMANT Sarah Thurman
(Address) 3501 Washington

15. FILED MAY 23 1927 19 May C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1927

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to May 18, 1927, that I last saw him alive on May 18th, 1927, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrage
Apoplexy
82A (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

7401

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J C Banagy, M. D

, 19 (Address) 4828 N. Broadway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St Mathews Cem	5-23-1927

20. UNDERTAKER	ADDRESS
Fred M Williams	4561 Delmar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD