

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

Do not use this space.

20523

AUG 18 1927

**1. PLACE OF DEATH**

County North  
Township St. Charles  
City St. Louis (No. 1)

Registration District No. 903  
Primary Registration District No. 6217

File No. 13  
Registered No. 13 Ward

**2. FULL NAME**

Marshall Nail

(a) Residence: No. 67 St. Mo. Ward.

(Usual place of abode)  
Length of residence in city or town where death occurred 67 yrs. - mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

male

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

married

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

Laura Nail

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

June 7, 1852

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

75

**8. OCCUPATION OF DECEASED**

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

Farmer

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Ohio

**10. NAME OF FATHER**

Henry Nail

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ohio

**12. MAIDEN NAME OF MOTHER**

Hudson

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ohio

**14.**

INFORMANT  
(Address)

Laura Nail  
Grant City, Mo.

**15.**

FILED

6/10, 1927  
John Andrews  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

June - 7 1927

**17.**

I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to June 7, 1927, and that I last saw him alive on May 31, 1927, and that death occurred, on the date stated above, at 9 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

(Hypertrophy) Prostate  
nephritis chronic

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. J. Root M. D.  
6/10, 1927 (Address) Grant City, Mo.

\*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**

Isadoro Cemetery

6 - 9 1927

**20. UNDERTAKER**

**ADDRESS**

On Brink Grant City Mo

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.

