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

Do not use this space.

31542

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. 4347 Lucky St. Ward)

File No. 8871

Registered No. .....

2. FULL NAME Marshall W. Douglas

(a) Residence. No. 4347 Lucky St., 11 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	Negro	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 26, 1887

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	4	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Miss

PARENTS

10. NAME OF FATHER O. H. Douglass
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.
12. MAIDEN NAME OF MOTHER Rachel Day
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.

14. INFORMANT O. H. Douglass
(Address) 4347 Lucky Ave

15. FILED OCT -1 1927 19.... Max C. Starkoff
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 2 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 9/13, 1927, to 10-2-1927 that I last saw him alive on 9-28, 1927, and that death occurred, on the date stated above, at 6:30 A. m.

23 THE CAUSE OF DEATH* WAS AS FOLLOWS:
30
Pulmonary Tuberculosis (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Renal Tuberculosis (duration) ..... yrs. 9 mos. ..... ds.

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? Tubercle Bacilli in urine + sputum
(Signed) G. A. Gaiskins, M. D
(Address) 3200 Lucas ave.

0 31 1893

*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. Peters	10-4-1927
20. UNDERTAKER	ADDRESS
Sates	4107 Finney

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.