

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

Do not use this space.
15355
15088
File No. _____
Registered No. **4289**
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Sanitarium**)

2. FULL NAME Sanders Cain

(a) Residence. No. **Unknown** St. **13** 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 | **Colored** | **Unknown**

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

Unknown

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
About 50

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) " "

14. INFORMANT **Wm Dever**
(Address) **Coroner Office**

15. FILED **APR 20 1928** **Wm C. Stokely** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-13-28** 19

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, _____, _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

CONTRIBUTORY (SECONDARY) **N. M. A.**

18. WHERE WAS DISEASE CONTRACTED **1010 W**
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) **Wm Dever** M.D.
4/19/28 (Address) **Dep Coroner**

*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 **Potters Field** DATE OF BURIAL **4/20 1928**

20. UNDERTAKER **Sales** ADDRESS **4107 Finney**

WRITE IN INK. WITH UNFADING INK. THIS IS A PERMANENT RECORD

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.

