

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

Do not use this space.

22827

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis mo.* (No.)

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **6856**
St. Ward)

2. FULL NAME

Shepard Sanders
(a) Residence. No. *1119 N 15 St.* St. *23* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *54* yrs. *4* mos. *10* da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *Col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Feb 17 1874*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 17 1874*

7. AGE YEARS MONTHS DAYS IF LESS than day, hrs. or min. *47* yrs. *4* mos. *10* days

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Janitor*
(b) General nature of industry, business, or establishment in which employed (or employer) *unknown*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Abbeville Miss*
(STATE OR COUNTRY)

10. NAME OF FATHER *unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Abbeville Miss*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Rosie A. Smith*

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

14. INFORMANT *Matie Hines*
(Address) *1119 N 15 St*

15. FILED *JUL 1 1928* *Wm C. Standley*
19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6/27/28*

17. I HEREBY CERTIFY That I attended deceased from *6/24/1928* to *6/27/28* 19... and that I last saw him alive on *6/27/28*, 19... and that death occurred, on the date stated above, at *30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dropsey
90B
do not know (duration) yrs. mos. da.
CONTRIBUTORY *asthma cardiac*
(SECONDARY) *non tubercular*
do not know (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *do not know*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *E. R. Hines*, M. D.

, 19 (Address) *224 Jefferson*

*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 *Greenwood* DATE OF BURIAL *7-1-28*

20. UNDERTAKER *B. Leonard and Co* ADDRESS *2702 Lawton*

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.

2949

