

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

Do not use this space.

6566

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City **St. Louis, Mo.** (No. **City Hospital #2**)

File No.

Registered No. **1382**

St. Ward)

2. FULL NAME

Marshall Sanford

(a) Residence. No. **2914 Morgan** St. **21** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **5** 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

col

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

Single

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

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

unknown

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

abt 50

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8. OCCUPATION OF DECEASED

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

Poster

(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.

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

(Address)

C. Ettrude Creath
City Hospital #2

15.

FILED

19

19

19

19

Paul C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

2/4/30 19

17.

I HEREBY CERTIFY, That I attended deceased from **1-26-1930** to **2-4-1930** that I last saw him alive on **2-4-1930** and that death occurred, on the date stated above, at **5 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhages
82A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. 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?

(Signed) **H. C. Stale**, M. D.

2/4/30 (Address) **City Hosp #2**

*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

Washington Park **2-10 1930**

20. UNDERTAKER

ADDRESS

Cinkie Toney 3129 Lucas

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.

WRITE-PLAINLY, WITH-ONWARDING INFORMATION THIS IS A PERMANENT RECORD

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2
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