

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

Do not use this space.

16264

1. PLACE OF DEATH

County Jackson
Township Ross
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 252
Registered No. 252
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1290 1/2 Chas. Sanford W.D.
(Usual place of abode) Oakland Hotel Mo. Ave. & Grand

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 15-1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
50 yrs 2 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Smith & Leach
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Sedalia
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Albert Sanford

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

12. MAIDEN NAME OF MOTHER Lenna L. Thomas

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

14. INFORMANT Mrs. J. Garlusk
(Address) H. of Min. Ave. K.C.

15. FILED 5/21 1930 M. M. Crowe
REGISTRAR Arer

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-18 1930

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:

Accidental fracture skull 185A 194B
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) fell from machinery
skull fracture (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? History & Hospital
(Signed) Stanley M. Hall, M. D.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Auburn Cem. Hts. Mo. DATE OF BURIAL 5/29-30

*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.

20. UNDERTAKER W. B. Lester ADDRESS K.C.

WRITE PLAINLY, 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.

