

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

Do not use this space.

34136

**1. PLACE OF DEATH**

County ..... Registration District No. ....  
Township ..... Primary Registration District No. ....  
City St. Louis Mo (No. City Hospital #2)

File No. ....  
Registered No. 9490  
St. .... Ward)

**2. FULL NAME**

John Marshall  
(a) Residence, No. 4329 W. Belle 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 20 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) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
64 50 - - - -

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Waiter 247  
10. Date deceased last worked at this occupation (month and year) Unknown 11. Total time (years) spent in this occupation unk

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark 2

13. NAME Kato Marshall

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 21

17. INFORMANT A. Berkey Death #  
(ADDRESS) City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL

PLACE City Hospital #2 DATE Oct 26th, 1932

19. UNDERTAKER Charles J. Wagoner  
(ADDRESS) 4107 Swansy Avenue

20. FILED Oct 26 1932 19 May C. Starker  
Registrar.

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-23, 1932

22. I HEREBY CERTIFY, That I attended deceased from 10-18, 1932, to 10-23, 1932

I last saw him alive on 10-23, 1932 Death is said to have occurred on the date stated above, at 3:55 p.m.

The principal cause of death and related causes of importance were as follows:

83  
34  
Cerebral (General) Paralysis  
of Basal Ganglia  
Other contributory causes of importance: (1)

Name of operation the C Date of 2  
What test confirmed diagnosis the C Was there an autopsy? 2

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify Cerebral Paralysis  
(Signed) C. Smith, M. D.  
(Address) City Hospital #2

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.

