

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.

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

40474
Do not use this space.

DEC 1 1939

1. PLACE OF DEATH 2

(a) County Pemiscot Registration District No. 650

(b) Township Spring Valley Primary Registration District No. 8572 Registered No. _____

(c) City Steele, (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert A. Sandford

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 28, 1938

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	61	10	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER

13. NAME Unobtainable

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

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT J. L. Sullivan
 (ADDRESS) Steele, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Sandford Cemetery DATE 9/16/39

19. FUNERAL DIRECTOR (NAME) Holt Funeral Home
 (ADDRESS) Blytheville, Ark.

20. FILED 12-1 1939 850
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1939, to Sept. 15, 1939

I last saw him alive on Sept. 13, 1939. Death is said to have occurred on the date stated above, at 8:15 P.m.

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

acute melenia cerebral type

Date of onset 9-13-39

Other contributory causes of importance:
cerebrovascular with 1 yr. ago
post meningitis

Name of operation _____ Date of _____

What test confirmed diagnosis? D+S Was there an autopsy? no

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? no

If so, specify _____
 (Signed) A. H. Shirley, M. D.
 (Address) Hayti, Mo.

RECEIVED

District Health Officer No. 3,

District File Number 1239-70

Date Filed 12/8/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.