

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

Do not use this space.

17369

**1. PLACE OF DEATH**

County.....

Registration District No. **701**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.**

(No. **Barnes Hospital**)

File No. ....

Registered No. **4431**

St. .... Ward

**2. FULL NAME** **Thomas Floyd Sexton**

(a) Residence No. **6737 Julian Ave.** St. **12** Ward. **University City Mo.**  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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

**White**

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

**Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

**Ella Hanson Sexton**

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

**Dec 23, 1878**

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, ..... hrs. or ..... min.

**51**

**4**

**9**

8. OCCUPATION OF DECEASED

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

**Ret Banker**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

**Millersburg Mo**

(STATE OR COUNTRY)

10. NAME OF FATHER

**Jessie G. Sexton**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

**Mo**

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

**Julia Matheny**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

**Rockport Mo**

(STATE OR COUNTRY)

14. INFORMANT

**Ella H. Sexton**

(Address)

**6737 Julian**

15. FILED

19

**May C. [Signature]**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 2 1930**

17.

I HEREBY CERTIFY, That I attended deceased from

**April 15 1930**, to **May 2 1930**, and that I last saw him alive on **May 2 1930**, and that death occurred, on the date stated above, at **1:25 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Brain Tumor Benign**

**Lobar pneumonia**

CONTRIBUTORY (SECONDARY)

**Lobar pneumonia**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Robert M. [Signature]** M. D.

**5-3-1930** (Address) **519 University Club Bldg.**

\*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

**Valhalla Cem.**

DATE OF BURIAL

**May 5 1930**

20. UNDERTAKER

**Alexander & Sons**

ADDRESS

**6175 Dehuar**

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. BUREAU OF VITAL STATISTICS, MISSOURI STATE BOARD OF HEALTH. Do not use this space.

Continued

10/1/42

