

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007599  
STATE FILE NUMBER  
2-1513

FILED MAR 2 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>7</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4252 W. Bell</i>		Length of stay in lb <i>50 yrs</i>	
d. STREET ADDRESS <i>4252 West Bell</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type in print) First <i>Milton</i> Middle <i>L.</i> Last <i>Sanford</i>		4. DATE OF DEATH Month <i>2</i> Day <i>10</i> Year <i>59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-28-1880</i>
9. AGE (In years at birthday) <i>78</i>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Huckster vegetable</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Huckster</i>	
11. BIRTHPLACE (City and state or country) <i>Marshall Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Milton Sanford</i>		13b. MOTHER'S MAIDEN NAME <i>Elizabeth Booker</i>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Elizabeth Sanford</i> Address <i>4252 West Belle</i>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hours</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertensive Heart Disease</i>		<i>2 years</i>	
DUE TO (c) <i>443 X</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Decubiti ulcers and malnutrition</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <i>June 1959</i> to <i>Feb 10 1959</i> and last saw him alive on <i>Feb 9, 1959</i> Death occurred at <i>1 am</i> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>G. M. Turner, M.D.</i> (Degree or title)		22b. ADDRESS <i>3861 St Louis Ave.</i>	
22c. DATE SIGNED <i>2-12-59</i>		23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Rem</i>	
23b. DATE <i>2-16-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cem.</i>	
23d. LOCATION (City, town, or county) <i>St. Louis</i>		(State) <i>Mo.</i>	
24. FUNERAL DIRECTOR <i>Manuel Und. Co.</i> ADDRESS <i>1711 N. Taylor</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 13 '59</i>	
26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Ald*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.