

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

Do not use this space.

14928
1110

1. PLACE OF DEATH

County Jackson
Township 15th
City Kansas City, Mo. (No. St. Marys Hts)

399

Registration District No. _____
Primary Registration District No. 1002

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

2. FULL NAME

Edward M. Alford

(a) Residence. No. Dodson Mo. St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 16 - 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>64</u>	<u>6</u>	<u>15</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) R R Man
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Canada

10. NAME OF FATHER William H. Alford

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) England

12. MAIDEN NAME OF MOTHER Sarah McDonald

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) England

14. INFORMANT William T. Alford
(Address) 192 3 Linwood Blvd

15. FILED 4/28 1929 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1929

17. I HEREBY CERTIFY That I attended deceased from Apr 23 1929 to Apr 27 1929 that I last saw her alive on Apr 27 1929, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstetrical Abortion
12 2 11
12 9

(duration) yrs. mos. 8 da.
CONTRIBUTORY General Peritonitis
(SECONDARY) (duration) yrs. mos. 5 da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Dodson, Mo.

DID AN OPERATION PRECEDE DEATH: yes DATE OF Apr 24 - 29

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy finding

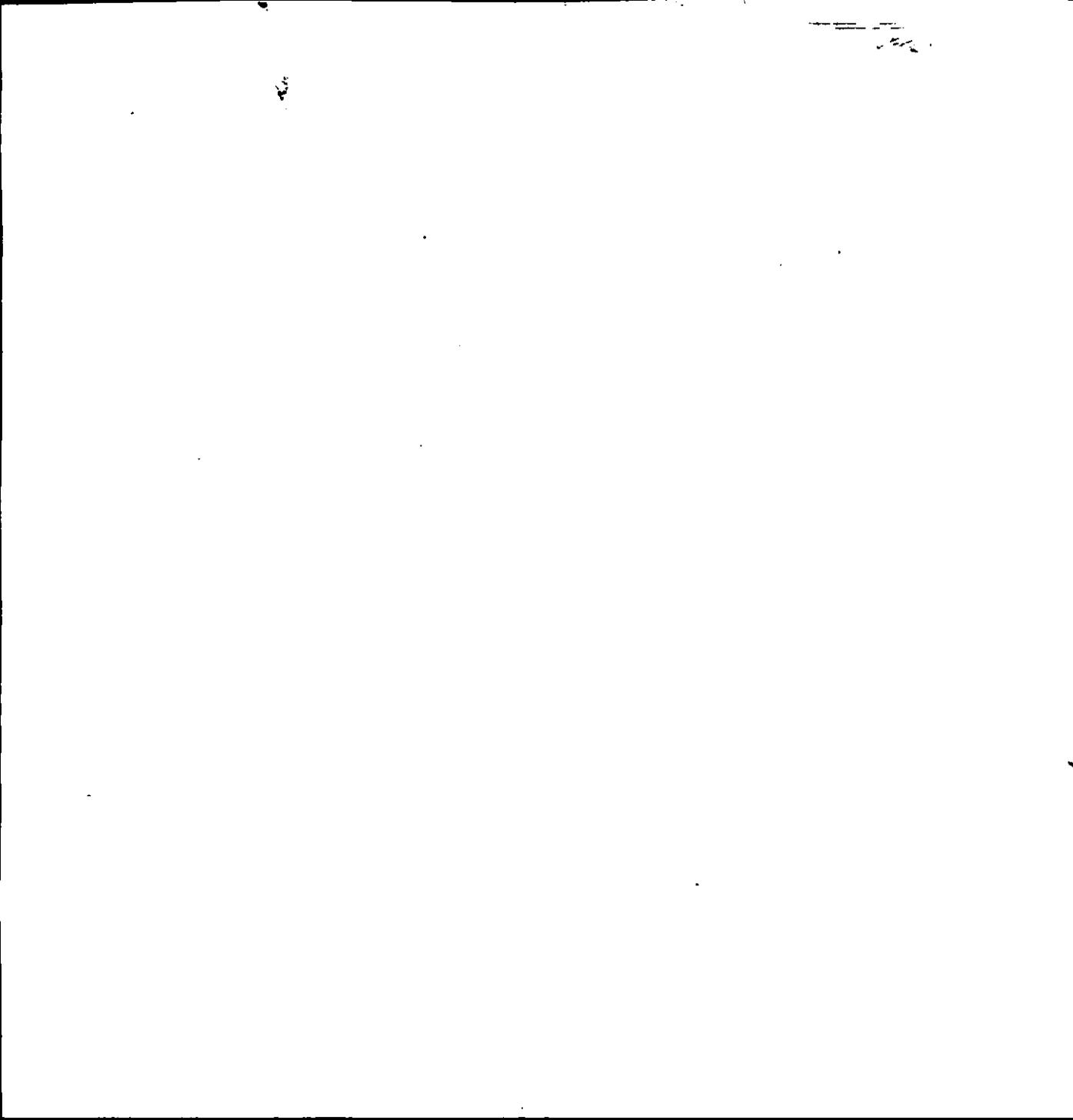
(Signed) J. C. Leasler, M. D.
Apr 27, 1929 (Address) 1001 Chamber Bldg

*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 Van Wert Ohio DATE OF BURIAL April 29, 1929

20. UNDERTAKER John H. Wagner ADDRESS 1401 Grand Ave

PARENTS



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 1973
 City St. Louis (No. St. Ward)

2. FULL NAME

Edward Alford

(a) Residence. No. St. Ward.
 (Usual place of abode)

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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) W

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
 (Address)

15. FILED 4/28, 29 M. M. Leonard REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/27 1929

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:

Intestinal obstruction
Valvular proident
Sigmoid Colon

CONTRIBUTORY (SECONDARY) 11801 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. C. Leath, M. D.

, 19 (Address) 1001 Chambers 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..... DATE OF BURIAL.....
 19

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

S-14928