

DEC'D SEP 20 1936

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

28487
Do not use this space.

1. PLACE OF DEATH 3

(a) County Callaway Registration District No. 104

(b) Township _____ Primary Registration District No. 3008 Registered No. 210

(c) City Fulton, Mo. (d) Street No. State Hospital # 1 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 0 yrs. 0 mos. 28 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Alford 416

(a) Residence, No. Frankford, Mo. 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 Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1920

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>18</u>	<u>07</u>	<u>07</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

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) Frankford, Mo.

FATHER

13. NAME Nelson Alford

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

MOTHER

15. MAIDEN NAME Sie Alford.

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 23 1938

22. I HEREBY CERTIFY, That I attended deceased from July 26, 1938, to Aug 23, 1938
I last saw h.i. in alive on Aug 22, 1938. Death is said to have occurred on the date stated above, at 12:30 p.m.
The principal cause of death and related causes of importance were as follows:
Epilepsy - since childhood

Other contributory causes of importance: \$5

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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 None
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) F. H. Barnett, M. D.
104 (Address) Fulton, Mo.

17. INFORMANT State Hosp. Records
(ADDRESS) Fulton, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Frankford, Mo. DATE Aug 25, 1938

19. FUNERAL DIRECTOR (NAME) Geo. H. Swell
(ADDRESS) Fulton, Mo.

20. FILED Aug 28, 1938 R. N. Crews
Local Registrar.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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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,

Geo Wallace

or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Geo Wallace

Licensed Embalmer No..... *3373*

P. O. Address..... *Fulton mo*

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.