

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

PLACE OF DEATH  
County Pemiscot  
Township Virginia  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 655 File No. 30382  
Primary Registration District No. 5872 Registered No. 27

If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph Franklin Alford

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Sep 15th, 1911 (Month) (Day) (Year)  
AGE 1 yrs. 13 mos. 13 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

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

BIRTHPLACE

(City or town, State or foreign country) Pemiscot County, Mo

PARENTS

NAME OF FATHER

Monroe Alford

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Traneer

MAIDEN NAME OF MOTHER

Mollie Young

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Pemiscot

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) See Alford

(ADDRESS) Missouri, Mo

Filed Sep 28th, 1912 H. J. Barnes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep 28th, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sep 22nd, 1912, to Sep 26th, 1912, that I last saw him alive on Sep 26th, 1912, and that death occurred, on the date stated above, at 12 a.m. The CAUSE OF DEATH\* was as follows:

Cholera Infantum  
119 A

Contributory

(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. A. Scheraga M. D.

Sep 28, 1912 (Address) St. Louis, Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

St. Louis, Mo

UNDERTAKER

A. C. LeFoy

DATE OF BURIAL

Sep 28th, 1912

ADDRESS

St. Louis, Mo

# PLACE OF DEATH

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

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

### FULL NAME

#### PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_ (If file the word)

DATE OF BIRTH \_\_\_\_\_

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE \_\_\_\_\_

if LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. ?

OCCUPATION \_\_\_\_\_

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

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

BIRTHPLACE \_\_\_\_\_

(City or town, State or foreign country)

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER \_\_\_\_\_

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER \_\_\_\_\_

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_

191 \_\_\_\_\_

REGISTRAR \_\_\_\_\_

#### MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_

(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191 \_\_\_\_\_, to \_\_\_\_\_, 191 \_\_\_\_\_,

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191 \_\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Contributory \_\_\_\_\_

(SECONDARY)

(Signed) \_\_\_\_\_

(Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

191 \_\_\_\_\_

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

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