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.

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

Do not use this space. 35169

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. ..... St. ..... Ward)

File No. .....

Registered No. 9902

2. FULL NAME Alexander Wofford

(a) Residence. No. 2400 Belleglade St., 17 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 6 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: Col

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22, 1894

7. AGE: YEARS 35 | MONTHS 1 | DAYS 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

245

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

2

PARENTS

10. NAME OF FATHER Charley Wofford

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

12. MAIDEN NAME OF MOTHER Anna Jones

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

14. INFORMANT Adella Wofford
(Address) 2400 Belleglade ave.

15. FILED OCT -8 1929 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/5 1929

17. I HEREBY CERTIFY, That I attended deceased from 8/18, 1929, to 10/5, 1929 that I last saw him alive on 10/4/1929 and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis 23A

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Dont Know

0 DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Sputum

(Signed) W. E. Hill, M. D.

, 19 (Address) 11-17 Jefferson

*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: Malvern Ark

DATE OF BURIAL: 10/12 1929

20. UNDERTAKER: R. M. C. Green

ADDRESS: 3517 Laclede ave.