

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

Do not use this space.

11248  
3303

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. 20 N. Garrison Ave)..... St. .... Ward)

**2. FULL NAME**

Ward Allred  
(a) Residence. No. 20 N. Garrison St. ..... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 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 Colo 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) Feb. 15, 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
47 1 15

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

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

PARENTS  
10. NAME OF FATHER Thos. Allred  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.  
12. MAIDEN NAME OF MOTHER Anne Davis  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Burton Allred  
(Address) 20 N. Garrison

15. FILED 17th 20th 1930 W. C. Harrison REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 30 1930

17. No physician in attendance  
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 3:30 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Chronic Myocarditis  
93c

CONTRIBUTORY (SECONDARY) 901B  
(duration) yrs. mos. da.

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

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

WAS THERE AN AUTOPSY? eyes

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. W. Fames, M.D.  
3/31, 1930 (Address) Dep. Coroner

\*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 Franklin, Ky. DATE OF BURIAL Apr. 4 1930

20. UNDERTAKER J. W. Harrison ADDRESS 2906 Linton

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.

WHITE PRINT, WITH UNFOLDING INK—THIS IS A PERMANENT RECORD

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