

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

Do not use this space.

21689

1. PLACE OF DEATH

County Jackson
Township Lea
City Keokuk

Registration District No. 399
Primary Registration District No. 1

File No. _____
Registered No. 2824
St. _____ Ward _____

2. FULL NAME

Kenneth Alford (Alford)

(a) Residence. No. 2029 Prospect St. 11 Ward _____

(If nonresident, give city or town and State)

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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16 - 31

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 11

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Keokuk, Mo.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Charley Alford

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

12. MAIDEN NAME OF MOTHER Alice Ferguson

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

14. INFORMANT Charles Alford
(Address) 2029 Prospect

15. FILED 6/29/31 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/27/31 1931

17. I HEREBY CERTIFY, That I attended deceased from 6/26/31 1931 to 6/27/31 1931 that I last saw him alive on 6/27/31 1931, and that death occurred, on the date stated above, at 8:15 a a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhagic Disease of The New Born

Hold (duration) yrs. mos. ds.
97A

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage (duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Evan - Lab
(Signed) W. M. Howard M. D.

(Address) Mercy Hosp

*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 Forest Hill DATE OF BURIAL June 29, 1931

20. UNDERTAKER Rose & Henderson ADDRESS 1 S. Jackson

WHITE 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.

