

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42240

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11056**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Audrain		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 11	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Vandalia		4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1949
d. FULL NAME OF (If not in hospital or institution, give street address or locality) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			d. STREET ADDRESS (If rural, give location) NR.		
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) P. c. (Last) Alford			4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 1, 1855		9. AGE (in years last birthday) 94 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 18 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME James L. Alford		13b. MOTHER'S MAIDEN NAME Unknown James		14. NAME OF HUSBAND OR WIFE Mattie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. L. B. Alford, 7442 Buckingham		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) degenerative heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) nephritis II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. prostatic hypertrophy				INTERVAL BETWEEN ONSET AND DEATH several yrs. several yrs.
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 91		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5928		
22. I hereby certify that I attended the deceased from 12/17/49 to 12/23/49 , that I last saw the deceased alive on 12/22/49 , and that death occurred of cause m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Edw. J. Sievers			23b. ADDRESS 634 N. Grand Ave		23c. DATE SIGNED 12/31/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-23-49	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Vandalia, Mo.	
DATE REC'D BY LOCAL REG. DEC 23 1949		REGISTRAR'S SIGNATURE J. B. Farter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, 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, fact should be so stated above.