

FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18393

318

1003

STATE FILE NUMBER 4600

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis ✓		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clayton 4452 0		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	STREET ADDRESS 7442 Buckingham Drive (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LELAND Middle BARTON Last ALFORD			4. DATE OF DEATH Month MAY Day 14, Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1885	9. AGE (In years last birthday) 71 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Vandalia, Missouri. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John P. Alford			14. MOTHER'S MAIDEN NAME Unk. Heckert		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Clayton, Mo. Mrs. Florence Alford 7442 Buckingham Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 12 hrs
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 420.1			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from MAY 1956 to MAY 14, 1957 and last saw her/him alive on MAY 14, 1957 Death occurred at 12:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Charles N. Jensen M.D.			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 5-14-57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 5-17-1957	23c. NAME OF CEMETERY OR CREMATORY Vandalia Cemetery		23d. LOCATION (City, town, or county) (State) Vandalia, Missouri
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar Blv'd.			25. DATE RECD. BY LOCAL REG. MAY 15 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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