Form V. S. 1-A
DEPARTMENT OF COMMERCE
Bureau of the Census

# COMMONWEALTH OF KENTUCKY

Department of Health
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

State File No. [illegible]
Registrar's No. [illegible] 309

Registration District No. 1713 Primary Registration District No. 85-21

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Riverside, Ky. (If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky (b) County Warren
(c) City or town Riverside (If outside city or town limits, write RURAL)
(d) Street No. (If rural give precinct)
(e) If foreign born, how long in U. S. A.? years

3(a) FULL NAME Harvey Lee Alford
3(b) If veteran, Name war
3(c) Social Security No.
4. Sex M
5. Color or race W
6(a) Single, widowed, married, divorced Married
6(b) Name of husband or wife Dora Alford
6(c) Age of husband or wife if alive 44 Years
7. Birth date of deceased 2 (Month) 8 (Day) 1875 (Year)
8. AGE: Years 69 Months 11 Days 25 If less than one day hr. min.
9. Birthplace Greencastle, Ky
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Calvin Alford
13. Birthplace Ky.
MOTHER 14. Maiden name Malissa Golf
15. Birthplace Ky.
16(a) Informant's own signature Mrs. Ora Duvelese [handwritten]
(b) Address 1819 Wilkins St. Indianapolis 3 Ind
17. BURIAL, CREMATION, OR REMOVAL
Place Riversode, Ky. Date 2-5 1945
18(a) Signature of funeral director Smith Funeral Home
(b) Address Morgantown, Ky.
19(a) 7-7-45 (Date received by local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH Feb. 3, 1945
21. I hereby certify that I attended the deceased from Feb 1 1945 to Feb 3 1945, that I last saw him alive on Feb 3 1945 and that death occurred on the date stated above at 6:00 P.M.
Immediate cause of death Pneumonia DURATION
Due to Influenza
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. E. Palmore M.D. (M. D. or other)
Address Date signed