

NOV 24 1930

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

Do not use this space.

1. PLACE OF BIRTH

County Douglas
Towship Myatt
City Mary Beal Alsup (No. _____)

Registration District No. 389
Primary Registration District No. 5343

File No. 32843
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ 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 + 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
64 2 3

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Roda Hudson

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

14. INFORMANT Jim Kuslaw
(Address) Lawton Mo

15. FILED Oct 12, 1930 Joa Thompson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 19 30

17. I HEREBY CERTIFY, That I attended deceased from Sept-19, 1930 to Oct-11, 1930
that I last saw her alive on Oct-7, 1930 and that death occurred, on the date stated above, at Lawton Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral
Apoplexy
(duration) _____ yrs. _____ mos. 20 da.
CONTRIBUTORY Arteriosclerosis
(SECONDARY) (duration) 4 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED? Lawton Mo
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? Joa Thompson
(Signed) _____, 19 _____ (Address) Lawton Mo

*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 State Line Ark DATE OF BURIAL Oct 12, 1930

20. UNDERTAKER None ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Douglas
Township Wyatt
City (No.)

Registration District No. 289
Primary Registration District No. 1-3-4-3

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER M Beal

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Terre Haute
(STATE OR COUNTRY) Ind

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
(Address)

15.

FILED Oct 12 1930 W A Thompson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 11 - 1930

17. I HEREBY CERTIFY That I attended deceased from , 1930, to , 1930, that I last saw him alive on , 1930, and that death occurred, on the date stated above, at .

THE CAUSE OF DEATH WAS AS FOLLOWS:

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D.
, 19 30 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

NOTE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. C. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-32743