

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

29201

Registration District No. 821

Primary Registration District No. 5801

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Matthews, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
(years, months or days)

8. (a) PRINT
FULL NAME

Charles Alsop 121

8. (b) If veteran,
name was _____

8. (c) Social Security
No. _____

4. Sex Male

5. Color or
race White

6. (a) Single, widowed, married,
divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased April 22 1940
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

3

25

hr.

min.

9. Birthplace Matthews, Mo. R. #3

(City, town, or county)

(State or foreign country)

10. Usual occupation Driver

11. Industry or business _____

12. Name Charles E. Alsop

13. Birthplace Irises

(City, town, or county)

(State or foreign country)

14. Maiden name Vilma Moore

(City, town, or county)

(State or foreign country)

15. Birthplace Kennett

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Charles E. Alsop

(b) Address Matthews, Mo. R. #3

17. (a) Burial (b) Date thereof Aug 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Matthews, Mo

18. (a) Signature of funeral director John Allison

(b) Address Irises, Mo

19. (a) 9-9-40 (b) W. H. Brant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Matthews, Mo "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17
year 1940 hour 9:00 minute _____ M.

21. I hereby certify that I attended the deceased from before death to 1940
that I last saw him alive on 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tracheo Bronch
of Case - Whooping Cough
Duration 10 Days

Due to _____
Due to 9

Other conditions Complicated by Colitis
(Include pregnancy within 3 months of death) 10 Days

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? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature E. E. Jones (M. D. or other) _____

Address Kelburn, Mo Date signed Aug 17 1940

RECEIVED

District Health Officer N

District File Number 240-14

Date Filed 9/10/4

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.