

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22538

5-43  
5-17-39  
X36671

State File No. \_\_\_\_\_  
Registrar's No. 16

FILED JUL 8 1946  
Registration District No. 378 Primary Registration District No. 4552

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

1. PLACE OF DEATH:  
(a) County Wright  
(b) City or town Mtn. Grove  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: no  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Lifetime years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Wright  
(c) City or town Mtn. Grove  
(If outside city or town limits, write "RURAL")  
(d) Street No. no  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

3. (a) PRINT FULL NAME JAMES SHELTON ALSUP  
3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 5  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Phoebe Dusley  
6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased: October 11, 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar. 5 - 1946 to May - 5 - 1946  
that I last saw him alive on May - 4 - 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 6 Days 27  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Atherosclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Douglas County Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_  
12. Name of father Tom Alsup  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Swinton  
15. Birthplace Douglas Co., Mo.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 97

16. (a) Informant Jack Alsup  
(b) Address Mtn. Grove, Mo.  
17. (a) Burial (b) Date thereof May 7, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Glendon Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Bruce Barber  
(b) Address Mtn. Grove Mo.  
19. (a) 7-2-46 (b) A. B. Amis  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature W. H. Perry M.D. (M. D. or \_\_\_\_\_)  
Address Mtn. Grove Mo. Date signed 5-6-46

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**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, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

July  
16

Registrar's No.

Registration District No. 378

Primary Registration District No. 4552

## 1. PLACE OF DEATH:

(a) County Wright  
(b) City or town North Shore  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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

## 3. (a) PRINT FULL NAME

James S. Alsup3. (b) If veteran, \_\_\_\_\_  
name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m5. Color w  
race6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased: Oct 11 1946

(Month)

(Day)

(Year)

8. AGE:

Years 82

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day \_\_\_\_\_

hr. min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation Retired farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) A. E. Ames  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")(d) Street No. \_\_\_\_\_  
(If rural, give location)(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

22538