

FILED DEC 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40413

BIRTH NO. _____		REG. DIST. NO. <u>50</u>		PRIMARY REG. DIST. NO. <u>5176</u>		Registrar's No. <u>44</u>		
1. PLACE OF DEATH a. COUNTY <u>CAMDEN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>CAMDEN</u>				
b. CITY OR TOWN <u>RURAL, AUGLAIZE</u>		c. LENGTH OF STAY (In this place) <u>2 yrs.</u>		c. CITY OR TOWN <u>RURAL AUGLAIZE</u>		15 0 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>SMILES NORTH RICHLAND MO</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>WILLIAM</u> c. (Last) <u>ALLSUP</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 7 1949</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG 8 1872</u>		
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		9. AGE (In years last birthday) <u>77</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Ill. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John William Allsup</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH MCGATHY</u>		14. NAME OF HUSBAND OR WIFE <u>MAE ALLSUP</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mae Allsup</u> ADDRESS <u>Richland, Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial heart disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial-Renal</u> DUE TO (c) <u>Vascular Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>3</u> <u>5 yrs.</u> <u>4222</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>Dec 2, 1949</u> , to <u>Dec 7, 1949</u> , that I last saw the deceased alive on <u>Dec 2, 1949</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John A. Michalovich D.O.</u>				23b. ADDRESS <u>Crocker Inn</u>		23c. DATE SIGNED <u>12-9-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-9-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Richland, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Dec. 15 1949</u>		REGISTRAR'S SIGNATURE <u>Zilpha Drow</u>		42 25. FUNERAL DIRECTOR'S SIGNATURE <u>Gene E. Hildren</u>		ADDRESS <u>Hartsville, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

RECEIVED

District Health Officer No. 7;

District File Number 11-49-1495

Date Filed 12-20-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Gene E. Zaldren

Licensed Embalmer No. 3865

P. O. Address Hartsville, Mo

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.