

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22865**

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>7</u>			
1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>					
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) <u>WEST PLAINS,</u>		c. LENGTH OF STAY (in this place) <u>50 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS,</u>		d. STREET ADDRESS (If rural, give location) <u>1152N. GARFIELD,</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>				d. STREET ADDRESS (If rural, give location) <u>046/0</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>KITTY B.</u> b. (Middle) <u>ALSUP</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>7-24-54</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>2</u>	8. DATE OF BIRTH <u>Jan 1 - 1978</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>WAVERLY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13a. FATHER'S NAME <u>J. N. BYERS</u>		13b. MOTHER'S MAIDEN NAME <u>ALMYRA HIBBARD</u>		14. NAME OF HUSBAND OR WIFE <u>B. M. ALSUP</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ORVAL ALSUP</u> ADDRESS <u>WEST PLAINS, 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CONGESTIVE HEART FAILURE 6 DAYS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>DIABETES MELLITUS</u> <u>SENILITY</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		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) _____ m.		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>7-19, 1954</u> , to <u>7-24, 1954</u> , that I last saw the deceased alive on <u>7-24, 1954</u> , and that death occurred at <u>8:40 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Jack D. Wilson, M.D.</u> (Degree or title)				23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>7-30-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>7-27-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS, MO</u>			
DATE RECD BY LOCAL REG. <u>8-4-54</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERTSONS, WEST PLAINS, MO</u> ADDRESS _____					

(Licensed Embalmer's Statement on Reverse Side)

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

461

046/0

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

A. S. Roberts

Licensed Embalmer No. *3477*

P. O. Address *Wheaton*

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.