

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38892

STATE FILE NUMBER

Registration District No.

347

Primary Registration District No.

4508

Registrar's No.

47

1. PLACE OF DEATH a. COUNTY Stone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stone			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Galena		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Galena		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		Length of stay in lb 5 years		d. STREET ADDRESS no street address		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle ALSUP Last ALSUP				4. DATE OF DEATH Month Oct. Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1882	
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Mountain Grove, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Alsup				14. MOTHER'S MAIDEN NAME Mary Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Mary Alsup, Galena, Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						INTERVAL BETWEEN ONSET AND DEATH 3 yr.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10-7-57 to 10-24-57 and last saw her/him alive on 10-22-57 Death occurred at 2:20 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE M. P. Brossman (Degree or title) M.D.		22b. ADDRESS Reeds Spring, Mo.		22c. DATE SIGNED 10-26-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/26/1957		23c. NAME OF CEMETERY OR CREMATORY Glenn Cemetery		23d. LOCATION (City, town, or county) (State) Nixa, Missouri	
24. FUNERAL DIRECTOR Harris Funeral Home, Clever, Mo.		ADDRESS @ 30-57		25. DATE RECD. BY LOCAL REG. Oct 30-57		26. REGISTRAR'S SIGNATURE Mrs. J. Elmer Brossman	

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.....
Signature of Student Embalmer

Signed.....
John Harris

Licensed Embalmer No. *439*

P. O. Address *Clever, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.