

FILED DEC 17 1957

STANDARD CERTIFICATE OF DEATH

46955  
STATE FILE NUMBER

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 2074

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Essex</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hosp.</b>				Length of stay in lb <b>22 Hrs</b>		d. STREET ADDRESS (If outside, give location) <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Oliver</b> Last <b>Alsup</b>				4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-17-1883</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				9b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		9c. AGE (In years last birthday) <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (City and state or country) <b>Stoddard, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Jim Alsup</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Liveray</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>John Alsup</b> Address <b>Essex, Missouri</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured left ventricle</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b>Coronary Thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <b>a. m.</b> Month, Day, Year <b>p. m.</b>							
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 <b>July 55</b> to <b>11-21-57</b> and last saw her alive on <b>11-21-57</b> Death occurred at <b>8:32 A. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Stephen Parker M.D.</b>				22b. ADDRESS <b>Bloomfield, Mo</b>		22c. DATE SIGNED <b>11-23-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 24-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bluff cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Stoddard Co. Missouri</b>	
24. FUNERAL DIRECTOR <b>CHILES UND. CO. BLOOMFIELD, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>11-27-57</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Ellen Hunter</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED **DEC 9 1957**

SCOTT CO. HEALTH DEPT.

CO. FILE No. **1257-250**

### 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 Lulu Cooper #3499, Student Embalmer No. 4119, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John C. Cooper  
Signature of Licensed Embalmer

Licensed Embalmer No. 4119

P. O. Address Bloomfield

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.