DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

15400

State File No.

FILED MAY 15 1940

Registration District No. 508-

Primary Registration District No. 3026

Registrar's No. 58.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County: Livingston

(b) City or town: Chillicothe (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 years, months or days)

In this community: 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Livingston

(c) City or town: Chillicothe (If outside city or town limits, write "RURAL")

(d) Street No.: 301 Cherry (If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME: William B. Alsbury 421

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Elizabeth Aulsbury

6. (c) Age of husband or wife if alive: 71 years

7. Birth date of deceased: Feb. (Month) 14 (Day) 1858 (Year)

8. AGE: Years 82 Months 2 Days 6 If less than one day — hr. — min.

9. Birthplace: (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation: Minister (Retired) 9

11. Industry or business: —

FATHER

12. Name: William Aulsbury 9

13. Birthplace: Unknown (City, town, or county) — (State or foreign country) 1

MOTHER

14. Maiden name: Unknown

15. Birthplace: " (City, town, or county) — (State or foreign country)

16. (a) Informant's own signature: Elizabeth Alsbury

(b) Address: Chillicothe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 23, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Edgewood Cem.

18. (a) Signature of funeral director: James D. Gordon

(b) Address: Chillicothe, Mo.

19. (a) 4-22-40 (Date received local registrar) (b) H. M. Grace M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20 year 1940 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1, 1938, to Apr. 20, 1940, that I last saw him alive on Apr. 20, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute heart dila. failure	
Due to: Diabetes Mellitus	2 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death): 54	

Major findings:
Of operations:
Of autopsy: none

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: H. M. Grace (M. D. or other)

Address: Chillicothe - Mo Date signed 4-22-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number 546-694
Date Filed MAY 9 1940

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 James D Gordon

Licensed Embalmer No. 1870

P. O. Address Chillicothe 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, above space should be left blank.