

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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

REC'D MAR 14 1938

5839

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Jackson Primary Registration District No. 1002 Registered No. 905  
 (c) City Kansas City (d) Street No. 1927 Penn St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Thomas Basworth 263

(a) Residence, No. 1927 Penn St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Ma 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Paul Basworth

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-3-1862

7. AGE YEARS 75 MONTHS 4 DAYS 21 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. retired  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Green Co. (STATE OR COUNTRY) Missouri

FATHER 13. NAME Carroll H. Basworth

14. BIRTHPLACE (CITY OR TOWN) no record (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Louisa - Masland

16. BIRTHPLACE (CITY OR TOWN) no record (STATE OR COUNTRY)

17. INFORMANT Miss Paul Basworth (ADDRESS) 1927 Penn

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE 2-26-38

19. FUNERAL DIRECTOR Wm. L. Foster (ADDRESS) St. Louis

20. FILED W. B. Brown 19 38 Dr. W. B. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-24 1938

22. I HEREBY CERTIFY, That I attended deceased from 2-24 1938 to 2-24 1938

I last saw him alive on 2-24 1938. Death is said to have occurred on the date stated above, at 2:10 PM

The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset

107a

Other contributory causes of importance:

Senility

Name of operation ..... Date of ..... no

What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ..... (Signed) D. H. DeMarino, M. D.

(Address) Sup. T. C. Gen. Hosp. T. C. M.

**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

**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.)**