

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 681
Registrar's No. 681

Registration District No. 701 Primary Registration District No. _____

1. PLACE OF DEATH: 1008
(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Bessie Basler
8. (b) If veteran, name war None
8. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Theodore
6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Nov. 21 1893
(Month) (Day) (Year)

| | | | |
|---------------|----------|----------|----------------------|
| 8. AGE: Years | Months | Days | If less than one day |
| <u>46</u> | <u>2</u> | <u>1</u> | hr. _____ min. |

9. Birthplace River Aux Vases Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Govro
13. Birthplace River Aux Vases Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Annie La Rose
15. Birthplace River Aux Vases Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Theodore Basler
(b) Address River Aux Vases, Mo.

17. (a) Removal (b) Date thereof 1/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation River Aux Vases, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington, Ave.

19. (a) JAN 23 1940
(Date of burial or cremation)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town River Aux Vases
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 22
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Jan. 15, 40
to 1-22-40, 1940
that I last saw her alive on 1-21-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death, Chronic Glomerular nephritis
Due to _____
Due to _____
Other conditions Myocarditis
(Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____
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?
While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature Albert H. Hoppe (M. D. or other) _____
Address 145 S. Grand Date signed 1/23/40

WHILE FILLING IN 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.

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..... *J. G. Sullivan*.....

Licensed Embalmer No..... *1122*.....

P. O. Address.....

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.