

No. 2
13-40
7-39
X23172

AUG 10 1940
Registration District No. 85

Primary Registration District No. 1001

State File No. 24684
Registrar's No. 809

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH 3
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 ds (Specify whether)

In this community 2cs (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Wm. Basler 446

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 Belle 6. (c) Age of husband or wife if

7. Birth date of deceased Apr 28, 1870 (Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 28 If less than one day hr. min.

9. Birthplace Macon Co, Mo. 9 (City, town, or county) (State or foreign country)

10. Usual occupation farmer 11. Industry or business 0

12. Name John Basler 13. Birthplace Germ. (City, town, or county) (State or foreign country)

14. Maiden name Mary O'Han 15. Birthplace Macon Co, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Clarence Basler Mo. (b) Address Callias Mo.

17. (a) REMOVAL (b) Date thereof 7-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation BEVIER, MO

18. (a) Signature of funeral director REEMAN & SON, INC. (b) Address St Joseph, Mo.

19. (a) 7-26-40 (b) A. J. Nestor (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County Macon

(c) City or town Callias (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 July day 26 year 1940 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from July 16, 1940, to July 26, 1940 that I last saw him alive on July 26, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-pneumonia 1 wk.

Due to chronic myocarditis ?

Due to with arteriosclerosis ?

Other conditions: (Include pregnancy within 3 months of death) h3c

Major findings: Of operations none Of autopsy none

Duration
1 wk.
?
?

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?

85 While at work? (Specify type of place) (e) Means of injury

23. Signature J. T. Odell (M. D. or other) Address St Joseph, Date signed 7/26/40

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3300

P. O. Address St Joseph M

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, fact should be so stated above.