

No. 2  
-13-40  
-17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33890  
8587

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

**PLACE OF DEATH:**

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Baptist 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

3. (a) PRINT FULL NAME Archie J. Basler

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 20 1928  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
12 3 27 hr. min.

9. Birthplace Ste. Genevieve Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

12. Name Henry W. Basler

13. Birthplace Bloomsdale Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Grass

15. Birthplace Weingarten Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry Basler

(b) Address Ste. Genevieve, Mo.

17. (a) Removal (b) Date thereof 10/18/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 17 1940 (b) J. F. Basler  
(Date received local registrar) (Signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town Ste. Genevieve (If outside city or town limits, write "RURAL") NR

(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 October day 17  
year 1940 hour 9 minute 10 A. M.

21. I hereby certify that I attended the deceased from October 13, 1940, to October 17, 1940.  
that I last saw him alive on October 16, 1940.  
and that death occurred on the date and hour stated above.

Immediate cause of death General peritonitis

Due to acute Appendicitis

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: acute Appendicitis  
Perforated Appendix  
Of autopsy General peritonitis

Duration

4 days  
3 days

**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)  
(e) Means of injury \_\_\_\_\_

23. Signature John D. Hayward (M. D. or other)  
514 Metropolitan Bldg Address Date signed 10/17/40

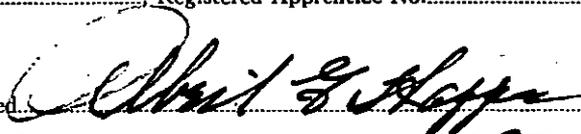
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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



Licensed Embalmer No..... 2971

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**