

MAILED APR 3 1942 2

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10059

Registration District No. _____ Primary Registration District No. 5037 Registrar's No. _____

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WRITE MAINLY IN UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: *Andara*
 (a) County *Jackson*
 (b) City or town *Bechal Wilson Trimp*
 (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 _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME *Judith Peter Basumussen*
 (b) If veteran, name war *No* (c) Social Security No. *No.*

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Widowed*
 (b) Name of husband or wife *Cecilia Basumussen* 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased *May 22 1882*
 (Month) (Day) (Year)

8. AGE: Years *89* Months *7* Days *0* If less than one day hr. _____ min. _____

9. Birthplace *Newman* 4 (City, town or county) (State or foreign country)

10. Usual occupation *Teacher*

11. Industry or business _____

12. Name *Hans Peter Basumussen*

13. Birthplace *Newman* 4 (City, town or county) (State or foreign country)

14. Maiden name *Walter Mostensen*

15. Birthplace *Newman* 4 (City, town or county) (State or foreign country)

16. (a) Informant *Agnes Basumussen*

(b) Address *Centralia Mo*

17. (a) *Burial* (b) Date thereof *12/24-1941*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Centralia Mo*

18. (a) Signature of funeral director *M. J. ...*

(b) Address *2589*

19. (a) *12/23-1941* (b) *Mrs. Arch. Blanton*
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 4
 (a) State *Missouri* (b) County *Jackson*
 (c) City or town _____ (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.? *0* years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *22* year *1941* hour *6* minute *30* M.

21. I hereby certify that I attended the deceased from *Dec. 14*, 19*41*, to *Dec. 22*, 19*41*, that I last saw him alive on *Dec. 22*, 19*41* and that death occurred on the date and hour stated above.

Immediate cause of death *Bronchial pneumonia*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 *12*

23. Signature *[Signature]* (M.D. or other) _____

Address *Centralia Mo* Date signed *12/27/41*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1011

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. _____

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, fact should be so stated above.