

FILED JAN 25 1943

10017000

Registration District No. 85

Primary Registration District No.

1. PLACE OF DEATH:

(a) County BILCHANAN
(b) City or town ST. JOSEPH
(c) Name of hospital or institution: State Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 13 years 9 mo 21 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. not given (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nettie M. Basket

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Widow
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown
7. Birth date of deceased 18 7 0
(Month) (Day) (Year)

8. AGE: Years 73 Months - Days - If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

10. Usual occupation none

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Nettie Basket Texas
(b) Address RFD - 4, Box 62, Corpus Christi

17. (a) (b) Date thereof 1-28-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chillicothe

18. (a) Signature of funeral director J D Gordon
(b) Address Chillicothe Mo. Os.

19. (a) 1-28-42 (b) Wesley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19
year 1943 hour 7:25 minute P. M.

21. I hereby certify that I attended the deceased from November 28 1942, to January 19 1943
that I last saw her alive on January 19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the left breast. Hypertensive Pneumonia. Chronic Hypo-Carditis
Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 50

Major findings: Of operations

Of autopsy Carcinoma left breast & Hypertensive Pneumonia. Ch. Hypo-Carditis
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 R B Sweeney (M. D. or other) MD
Address State Hosp # 2 Date signed 1-28-43
St. Joseph, Mo.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

1233

(Licensed Embalmer's Statement on Reverse Side)

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.