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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 22 1943

Registration District No. 5

Primary Registration District No. 5224

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Grand River
(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 _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 mi west Harrisonville
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Amos Calvin Basister

(b) If veteran, name war no (c) Social Security No. 482-07-2997

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1943 hour 8 1/2 minutes 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Myrtle May Basister 6. (c) Age of husband or wife if alive 6 1/2 years
7. Birth date of deceased Oct 29 1883
(Month) (Day) (Year)

Immediate cause of death Probably due to heart attack Duration _____

8. AGE: Years 60 Months 8 Days 16 If less than one day _____ hr. _____ min.

Due to _____
Due to _____

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

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

10. Usual occupation Farmer

Major findings: Of operations _____

11. Industry or business _____

12. Name Albert Marion Basister

13. Birthplace Orion Mo
(City, town, or county) (State or foreign country)

14. Maiden name Rachel Elizabeth Pleasant

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

16. (a) Informant Myrtle M. Basister

(b) Address Harrisonville, Mo

17. (a) Burial (b) Date thereof 7/18/43
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Orion, Cass, Mo

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) July 17, 1943 (b) Margaret Valle
(Date received by Registrar) (Registrar's signature)

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 B. M. Griffith (M. D. or other)

Address Harrisonville Date signed July 17, 1943

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

19
00

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 Ernest Remenberga

Licensed Embalmer No. 3368

P. O. Address Harrisonville, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

File No. **90V**

Registration District No. **59** Primary Registration District No. **5224** Registrar's No. **128**

1. PLACE OF DEATH:
(a) County **Cass**
(b) City or town **Rural**
(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 **Amos C. Lauster**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased **Oct 29 1888**
(Month) (Day) (Year)

8. AGE: Years **60** Months **8** Days _____ If less than one day _____ min.

9. Birthplace **M.O.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** Year **1943** noon _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Probably due to head attack**

Due to **Chronic indigestion**

Due to _____

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

Major findings: Of operations **92 d**

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) (c) Means of injury _____

23. Signature **P. M. Suffer** (M. D. or other) _____

Address **Lawrenceville** Date signed _____
Carroll Cass Co

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-246 (51)

E. M. Griffith
Hammocks
Crown