

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29999

State File No. _____

FILED SEP 26 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3731

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kerssach Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether)
In this community 32 years (years, months or days)

3. (a) PRINT FULL NAME

EMAX BASYE

3. (b) If veteran, name war World War one

3. (c) Social Security No. 286-12-4199

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive 12-1883 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 8 If less than one day hr. min. 253

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

10. Usual occupation Construction Engineer

11. Industry or business Kansas City Southern

12. Name Calaman Basye

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

14. Maiden name Eugene Field

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

16. (a) Informant H.C. S. R.R.

(b) Address H.C. S. R.R.

17. (a) Burial, cremation, or removal Burial (b) Date thereof 9-15-44 (Month) (Day) (Year)

(c) Place: burial or cremation Flora Hills

18. (a) Signature of funeral director Wm. H. Brown

(b) Address Wm. H. Brown

19. (a) 9-15-44 (b) N.C. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Jackson (b) County Jackson
(c) City or town Shuman Hills (Rural) (If outside city or town limits, write "RURAL")
(d) Street No. 87th Spring Valley Rd. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 15th year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 15th to Sept 15th, 1944, that I last saw him alive on Sept 14th, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Ca. Oesophagus
Due to Intoxication

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

Major findings: 46 a
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) (e) Means of injury _____

23. Signature J. G. Montgomery M.D. (M.D. or other) _____

Address Wm. H. Brown Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

SEP 19 8 1945

MAR -6 1945

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

Floyd B. Carson

Licensed Embalmer No.

4199

P. O. Address

Independence, 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, fact should be so stated above.