

S. No. 2  
M-5-43  
5-17-39  
I X36671

FILED SEP 13 1945

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 135

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1  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Marionville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Francis  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One week  
(Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway

(c) City or town Guilford  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Lena Basford

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18 year 1945 hour 11 minute 15 P M.

21. I hereby certify that I attended the deceased from Aug 11 1945 to Aug 18 1945  
that I last saw her alive on Aug 18 1945 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Frank Basford (deceased)

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

7. Birth date of deceased Aug - 11 - 1870  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Cardiac Failure  
Coronary Occlusion  
Chronic Myocarditis  
Arterio Sclerosis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 75 Months 0 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Lee County Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

Of autopsy 946

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

MOTHER FATHER

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

12. Name John Slagle

13. Birthplace Lee County Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Lockhart

15. Birthplace Lee County Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Jess Slagle

(b) Address Waverwood Me

17. (a) Burial (b) Date thereof 8-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cah Lane Waverwood

18. (a) Signature of funeral director Campbell Funeral Home

(b) Address Marionville Mo

19. (a) 8-23-45 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 W.P. Jackson (M. D. or other) \_\_\_\_\_  
Address Marionville Date signed 8-21-45

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**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..... *William Campbell* .....

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.**