. S. No. 2
0M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30652

State File No. _____

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 106

1. PLACE OF DEATH:

(a) County: Howell

(b) City or town: West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 305 St Louis St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community: 7 months

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Howell

(c) City or town: West Plains
(If outside city or town limits, write "RURAL")

(d) Street No.: 1
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No): 0

If yes, name country _____

3. (a) PRINT FULL NAME: Linda Sherill (Shown) Basinger

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Infant

6. (b) Name of husband or wife: _____

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: Jan (Month) 15 (Day) 24 (Year) 45

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

9. Birthplace: West Plains (City, town, or county) Mo (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name: Orval Basinger
13. Birthplace: Wildon (City, town, or county) Ark (State or foreign country)

MOTHER
14. Maiden name: Ida Barter
15. Birthplace: Cuba (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Orval Basinger
(b) Address: West Plains, Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof: 8 (Month) 22 (Day) 45 (Year)
(c) Place: burial or cremation: Homeland

18. (a) Signature of funeral director: Robertson
(b) Address: West Plains, Mo

19. (a) OCT 5, 1945 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

1519

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 22 year 1945 hour 1 minute 50 P.M.

21. I hereby certify that I attended the deceased from 8-19- 1945, to 8/22 1945; that I last saw her alive on 8-21 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bacillary Dysentery	4 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 2 No	
Of autopsy	

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature: Virgil D. Bailey (M. D. or other) D.O.

Address: Box 191 West Plains Mo Date signed 9/8/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 1045-518
Date Filed 10. 13-45.

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.