

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17267

State File No.

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether)  
In this community — years, months or days

3. (a) PRINT FULL NAME AUGUSTUS T. BASYE

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife ADRIENNE STOTT 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased Nov. 21 - 1873 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 5 25 hr. min.

9. Birthplace HOWARD Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

12. Name MICHAEL BASYE  
13. Birthplace HOWARD Co. Mo. (City, town, or county) (State or foreign country)  
14. Maiden name SARAH JOHNSON  
15. Birthplace HOWARD Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Towney Neach  
(b) Address Fayette, Mo.  
17. (a) REMOVAL (b) Date thereof MAY 19 1947 (Barial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation BIG SPRINGS

18. (a) Signature of funeral director C. S. Nunn  
(b) Address New Franklin, Mo.  
19. (a) May 30, 1947 (b) Dorothy Jean Basye (Date received local registrar) (Resident's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWARD  
(c) City or town RURAL (If outside city or town limits, write "RURAL")  
(d) Street No. R.R. RACHESPORT, MO. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 16 year 1947 hour 8 minute — P.M.

21. I hereby certify that I attended the deceased from May 12 to May 16, 1947; that I last saw him alive on May 16, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Decomposition Duration 1 mo.  
Due to Malignancy of stomach Unknown.  
Due to —

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Aspiration

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. M. Shaw (M. D. or other) M.D.  
Address Fayette, Mo. Date signed 5-27-47

(Licensed Embalmer's Statement on Reverse Side)

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
SHOULD BE  
CHARGED STATISTICALLY.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-5-47

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

L. L. Hall

Licensed Embalmer No. 3515

P. O. Address

New Franklin, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 28

Registration District No. 120

Primary Registration District No. 302K

1. PLACE OF DEATH:

- (a) County Howard  
(b) City or town Rayette  
(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

Augustus J. Basye

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive.

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 2 If less than one day, hr. min.

9. Birthplace (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (Date received local registrar) (b) (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 May year 1944 hour minute M.

21. I hereby certify that I attended the deceased from to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above. Immediate cause of death. Duration

adenocarcinoma of stomach

Due to.

Due to.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

17267