

Registration District No. 64

Primary Registration District No. 4110

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Salisbury

(c) Name of hospital or institution:  
E First Street 1  
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Harriet Matilda Basham

3. (b) If veteran, name war No.

3. (c) Social Security No.

4. Sex Female 5. Color or race BLK 6. (a) Single, widowed, married, divorced, widowed

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

7. Birth date of deceased 3 17 1869 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78 10 17 by min.

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

10. Usual occupation housewife

MOTHER FATHER

11. Industry or business

12. Name John A Kinchloe

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

14. Maiden name James F Newlan

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

16. (a) Informant Mrs Kinchloe

(b) Address Jefferson City Mo

17. (a) Burial (b) Date thereof 2-8-48 (Month) (Day) (Year)

(c) Place: burial or cremation Salisbury

18. (a) Signature of funeral director G. W. Winkelman

(b) Address Salisbury Mo

19. (a) 2/8/48 (Date received local registrar)

(b) G. W. Winkelman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton 21

(c) City, or town Salisbury 2  
(If outside city or town limits, write "RURAL")

(d) Street No. East First Street 0  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 4<sup>TH</sup> year 1948 hour SIX minute 30 P.M.

21. I hereby certify that I attended the deceased from 1940 to 1948 that I last saw her alive on FEB. 4<sup>TH</sup> 1948 and that death occurred on the date and hour stated above.

Immediate cause of death HEMORRHAGE

Due to TUBERCULOSIS ✓ YEARS

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 13 B 2

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) ~~EVNOIITD~~

(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? 2

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

23. Signature E. J. Eickhorst M. D. or other D.O.

Address Salisbury Mo. Date signed FEB 5, 48

WRITE PLAINLY—USE UNFADING BLACK INK—MARB-A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 3-4-48

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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

*Charles W. Winkelmeyer*

Licensed Embalmer No.

*38420*

P. O. Address

*Salisbury, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 64

Primary Registration District No. 4110

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Salsburg  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Hazel M Basham

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 1948 year, 17 hour, 4 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 Hemorrhage from lungs.

4. Sex F 5. Color or race B

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased March 17  
(Month) (Day) (Year)

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

Due to Tuberculosis Pulmonary

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

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

Of autopsy 13B

8. AGE: Years 78 Months 10 Days 10 If less than one day \_\_\_\_\_ yr. \_\_\_\_\_ min.

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

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)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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)

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 E. H. Richardson (M. D. or other) Do

Date signed \_\_\_\_\_

SUPPLEMENTARY

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

4251