

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1160

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 101	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 22 Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2205 Brooklyn Ave 1				d. STREET ADDRESS (If rural, give location) 2205 Brooklyn Ave			
3. NAME OF DECEASED (Type or Print) a. (First) Frances b. (Middle) Mae c. (Last) Bassett				4. DATE OF DEATH (Month) (Day) (Year) January 8 1949			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 5 - 1890	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Maid		11. BIRTHPLACE (State or foreign country) Glasgow Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William Wells		13b. MOTHER'S MAIDEN NAME Eddie Holliday		14. NAME OF HUSBAND OR WIFE Asa Bassett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bruce Wells 2205 Brooklyn			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 490				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 27, 1948, to Jan. 7, 1949 that I last saw the deceased alive on Jan. 7, 1949 and that death occurred after 2 m., from the causes and on the date stated above.							
23a. SIGNATURE D. M. Miller (Degree or title) M.D.				23b. ADDRESS 1816 Vine - Kls. Mo.		23c. DATE SIGNED 1-10-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 12 - 1949		24c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		24d. LOCATION (City, town, or county) (State) K. C. MO.	
DATE REC'D BY LOCAL REG. 1-10-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE West Appleton Jones		ADDRESS 1905 Kine St	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. 267

working under my personal supervision.

Student Nepoleon Jordan

Student Embalmer

Signed

W. H. West

Licensed Embalmer No. 2710

P. O. Address Kansas City 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.