

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11697

BIRTH NO. _____		REG. DIST. NO. 140		PRIMARY REG. DIST. NO. 3024		Registrar's No. 27	
1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard			
b. CITY (If outside corporate limits, write RURAL and give township) Fayette		c. LENGTH OF STAY (in this place) 20 da.		c. CITY OR TOWN Fayette		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Wells Convalescent Home				STREET ADDRESS (If rural, give location) 045/0			
3. NAME OF DECEASED (Type or Print) Emma		a. (First)		b. (Middle) Hall		c. (Last) Baskett	
4. DATE OF DEATH		(Month) Apr. 3, 1955		(Day)		(Year)	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Feb. 16, 1867	
9. AGE (In years last birthday) 88		10. MONTHS 1		11. YEAR 17		12. IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) Randolph Co. Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Augustus Hall		13b. MOTHER'S MAIDEN NAME Octavia Sebree		14. NAME OF HUSBAND OR WIFE William Crewdson Baskett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs John Lehane Fayette, Mo			
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) Cerebral hemorrhage ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs. 1 yr.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X				20. AUTOPSY? YES ☐ NO ☒	
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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June, 1947, to April 3, 1955, that I last saw the deceased alive on 4-4, 1955, and that death occurred at m., from the causes and on the date stated above.							
23a. SIGNATURE Mr. J. Shaw M.D.		(Degree or title)		23b. ADDRESS Fayette Mo.		23c. DATE SIGNED 4-5-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/6/55		24c. NAME OF CEMETERY OR CREMATORY City Cemetery		24d. LOCATION (City, town, or county) (State) Moberly, Missouri	
DATE REC'D BY LOCAL REG. 4-5-55		REGISTRAR'S SIGNATURE Mary R. Shell 436		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Salvador Carr Fayette, Mo			

(Licensed Embalmer's Statement on Reverse Side)

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, ~~only~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed... *Ralph A. Carr*

Licensed Embalmer No. *33*

P. O. Address *Jayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.