

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25506

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>389</u>		PRIMARY REG. DIST. NO. <u>5773</u>		Registrar's No. <u>20</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Summit Twp</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Holt Summit</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>3 mi East Holt Summit</u>				e. STREET ADDRESS (If rural, give location) <u>3 mi E Holt Summit</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Byrd</u> b. (Middle) <u>Edward</u> c. (Last) <u>BASINGER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 9 55</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Dec 26-1892</u>	9. AGE (In years last birthday) <u>72</u>	10. If under 1 year Days <u>7</u>	11. If under 1 hrs. Hours <u>15</u>	12. If under 1 hrs. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Labor</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John H. Basinger</u>			13b. MOTHER'S MAIDEN NAME <u>Sara Wolf</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Mary Fleming Holt Summit</u> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>				<u>7</u>	
		ANTECEDENT CAUSES					
		*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.					
		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.					
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 <u>July 25, 1953</u> , to <u>Aug 9, 1955</u> , that I last saw the deceased alive on <u>Aug 8, 1955</u> , and that death occurred at <u>5 a.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. Max Rusk M.D.</u>				23b. ADDRESS <u>New Bloomfield Mo</u>		23c. DATE SIGNED <u>Aug 9-1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 11/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Union Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Holt Summit Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Aug 9-55</u>		REGISTRAR'S SIGNATURE <u>LeRoy Claypool 393</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holt Claypool Sr</u>		ADDRESS <u>New Bloomfield Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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

Student.....  
Signature of Student Embalmer

Signed.....  
*Leroy Claypool*

Licensed Embalmer No. *441*

P. O. Address *New Haven*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.