

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030178

FILED VS SEP 9 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 340

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ste. Genevieve</u>					
b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <u>St. Francois Township</u>		Length of stay in 1b <u>2 Mos. 4 das.</u>		c. CITY OR TOWN <u>Ste. Genevieve</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 4</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>244 St. Mary's Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>J.</u> Last <u>BASLER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill wright for Pittsburg Plate Glass Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Zell, Missouri</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Jacob Basler</u>			13b. MOTHER'S MAIDEN NAME <u>Magdalena Braun</u>			14. NAME OF HUSBAND OR WIFE <u>Augusta Cecilia Giesler</u>			
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>489-03-4625</u>		17. INFORMANT Address <u>Records, State Hospital No. 4, Farmington, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized and marked - - -</u>							INTERVAL BETWEEN AND DEATH <u>6 yrs.</u>		
DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary tuberculosis, involving right upper lobe and senile psychosis.</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>June 26, 1959</u> to <u>August 30, 1959</u> and last saw him <u>alive</u> on <u>August 30, 1959</u>				Death occurred at <u>9:15 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>State Hospital No. 4</u> <u>Farmington, Missouri</u>		22c. DATE SIGNED <u>8-31-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ste. Genevieve, Mo.</u>					
24. FUNERAL DIRECTOR <u>Jerome A. Stanton</u> ADDRESS <u>Ste. Genevieve, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Aug. 31, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Jerome H. Steub*

Licensed Embalmer No. 3817

P. O. Address *St. Louis, Mo.*

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