

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009275

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 3572 Registrar's No. 27

FILED APR 14 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived at institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Prairie Twp.</b>		Length of stay in lb <b>000</b>	c. CITY OR TOWN <b>Sedalia</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>50 Hi-Way</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>903 Arlington St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <b>Thomas Edward Bast</b>			4. DATE OF DEATH Month Day Year <b>April 8, 1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Store</b>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <b>36</b> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Dr. Thomas W. Bast</b>		13b. MOTHER'S MAIDEN NAME <b>Ruth Bodwell</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Dr. T. W. Bast, Sedalia, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock &amp; hemorrhage fractured right lower maxilla</b> DUE TO (b) <b>hemorrhage in leg &amp; mediastinum</b> DUE TO (c) <b>fractured left leg</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>fractured left leg</b>			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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Two car collision</b>	
20c. TIME OF INJURY Hour Month, Day, Year <b>4-8-61</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>50 Highway</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Jackson MO</b>	
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Hugh H. Owens Coroner</b>		22b. ADDRESS <b>152 Union Station</b>	22c. DATE SIGNED <b>4-8-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Apr. 10, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Gillispie Funeral Home Sedalia, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>4-8-1961</b>	26. REGISTRAR'S SIGNATURE <b>J. B. Langford</b>

MAY 3 1961

APR 19 1961

APR 27 1961

MAY 4 1961

**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 D. B. Langsfeld

Licensed Embalmer No. 4962

P. O. Address Leis Summit

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.