

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 771 Primary Registration District No. 5887 Registrar's No. 101 62-030348

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 11 1962

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>Years</u>	c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mile S. of Ex. Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 mile south Ex. Spgs.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>Robert Champ Bassett</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1962</u>	
---	--	--	---	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1894</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Veterans administration,</u>	11. BIRTHPLACE (City and state or country) <u>Lawson, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>William Bassett</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Bisbee</u>	14. NAME OF HUSBAND OR WIFE <u>Lillie Opal Shelton</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. I</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs Robert C Bassett, Ex. Spgs, Mo</u>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		<u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive heart disease</u>	<u>sev. mos.</u>
	DUE TO (c) <u>Hypertension</u>	<u>sev. mos.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerosis</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 <u> </u> a.m. / p.m. Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION <u>Excelsior Springs, Mo.</u>	COUNTY <u>Clay</u>	STATE <u>Mo.</u>
---	---	--	---	-----------------------	---------------------

21. I attended the deceased from <u>Oct. 5, 1959</u> to <u>Sept. 6, 1962</u> and last saw <u>him</u> alive on <u>Sept. 6, 1962</u> Death occurred at <u>3:30 A.M.</u> m 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>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>9/7/62</u>
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/8/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo</u>
--	----------------------------	---	---

24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>9-8-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
16000
26000
3
4 0
5 1
6
7 0
8 0
94201
10
11
1290-0
13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

SEP 19 1962
OCT 10 1962

Burial permit issued 9/18/63 - E.H.

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

Ralph Van Landingham

Licensed Embalmer No. 4997

P. O. Address Quincy, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.