

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41698**

BIRTH NO. _____		REG. DIST. NO. 209		PRIMARY REG. DIST. NO. 3043		Registrar's No. 405		
1. PLACE OF DEATH a. COUNTY Marion County				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Shelby				
b. CITY OR TOWN Hannibal, Mo.		c. LENGTH OF STAY (in this place) 1 Mo.		c. CITY OR TOWN Shelbina		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Millers Rst Home 2202 Spruce				STREET ADDRESS (If rural, give location) X 1020				
3. NAME OF DECEASED (Type or Print) a. (First) HATTIE			b. (Middle) VIRGINIA		c. (Last) BASSETT		4. DATE OF DEATH (Month) (Day) (Year) 12-24-1954	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 7-18-1875		9. AGE (In years) (last birthday) 79	IF UNDER 1 YEAR (Month) (Day) 5 6	IF UNDER 24 HRS. (Hour) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house hold		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and State or Foreign Country) Monroe Co. Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Not known			13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) X		17. INFORMANT'S SIGNATURE OR NAME Otis Williams, Hannibal, Mo.		ADDRESS		
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) Inanition and Debilitation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pseudobulbar Palsy DUE TO (c) Chronic Paralysis Agitans II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 350X				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 12-1- , 19 54 , to 12-23- , 19 54 , that I last saw the deceased alive on 12-24 , 19 54 , and that death occurred at 7:00A m., from the causes and on the date stated above.								
23a. SIGNATURE E. O. Ingell 2 D.O. (Degree or title)				23b. ADDRESS 1909 Settles, Hannibal, MO		23c. DATE SIGNED 12/30/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-28-1954		24c. NAME OF CEMETERY OR CREMATORY Shelbina Cemty.		24d. LOCATION (City, town, or county) (State) Shelbina, Mo.		
DATE REC'D BY LOCAL REG. 1-5-55		REGISTRAR'S SIGNATURE Dr. E. M. Lucke By W. G. Fisher		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Barklew-Hawkins, Shelbina, Mo.				

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

RECEIVED JAN 15 1955
MARION CO. HEALTH DEPT.
DATE FILED JAN 15 1955

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 *W. H. Haines*

Licensed Embalmer No. *3490*
P. O. Address *St Albans*

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.