

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

34

FILED JAN 25 1955

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5010 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>									
b. CITY OR TOWN <u>Rural Bolckow</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Rural Bolckow</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>R.F.D. 2</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. 2</u> <u>0020</u> <u>0</u>									
3. NAME OF DECEASED a. (First) <u>Clarence</u> (Type or Print)			b. (Middle) <u>Russell</u>		c. (Last) <u>Bashor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-9-1955</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>5-16-1918</u>		9. AGE (in years last birthday) <u>36</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Flags Springs Mo</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Clarence Bashor</u>				13b. MOTHER'S MAIDEN NAME <u>Galdie Goporth</u>				14. NAME OF HUSBAND OR WIFE <u>Doris Bashor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>R.F.D. 2 Mrs. Doris Bashor Bolckow Mo</u> ADDRESS <u>no</u>							
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral removal</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Shotgun blast</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.										INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>E976X</u>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u>			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>R.F.D. #2 Bolckow, Andrew, Mo.</u>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan. 9, 1955 10:00 a.m.</u>			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>Fired 12 gauge shotgun into right temple.</u>							
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:00 a.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>W.S. Maxwell, D.D., Coroner</u> (Degree or title)						23b. ADDRESS <u>307 W. Main, Savannah Mo.</u>			23c. DATE SIGNED <u>1/10/55</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-11-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Star</u>			24d. LOCATION (City, town, or county) (State) <u>Union Star Mo</u>						
DATE REC'D BY LOCAL REG. <u>1-11-55</u>		REGISTRAR'S SIGNATURE <u>Lillian Spunk</u> <u>2-0</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Breit Funeral Home Savannah Mo</u> ADDRESS							

(Licensed Embalmer's Statement on Reverse Side)

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

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..... *E. C. Breit*.....

Licensed Embalmer No. *2650*

P. O. Address *Savanna*

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.