WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Wayne

Township Blackwater or Village or City

Registration District No. 892 File No. 28551

Primary Registration District No. 6194 Registered No. 25

(NO. , St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Chas. Wesley Bazzel

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	

DATE OF BIRTH July (Month) 31 (Day), 1911 (Year)

AGE yrs. 6 mos. Some ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X

BIRTHPLACE (City or town, State or foreign country) Otter Creek Mo.

PARENTS

NAME OF FATHER Irving Bazzel

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dent Co Mo

MAIDEN NAME OF MOTHER Nellie Buck

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Otter Creek Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Childers great grandma

(ADDRESS) Eaker Mo.

Filed Aug 8, 1912. J. L. McGhee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. (Month) X (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from , 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: 11 9 8

Had no physician. Cause of death given by Dr. Holtz that had treated baby prior to this, was Stomach and bowel trouble (Duration) yrs. mos. few ds.

Contributory (SECONDARY) 0 (Duration) yrs. mos. ds.

(Signed) M. D.

, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Near Cheonia Mo.	Feb. X, 1912
UNDERTAKER	**ADDRESS**
None	

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*____
(Month) (Day) (Year)

AGE

_____yrs. _____mos. _____ds.

If LESS than 1 day, ____hrs. or ____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory _____
(SECONDARY)
_____(Duration)_____yrs._____mos._____ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____yrs. ____mos. ____ds. In the State ____yrs. ____mos. ____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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