LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

36972

ACE OF DEATH

ounty Monroe — Registration District No. 582 — File No.

ownship ~~Jackson~~ — Primary Registration District No. 4344 — Registered No. 71

ity Paris, Mo (No. ..... St. ..... Ward)

LL NAME Samuel Staples Bassett

a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

le | 4. COLOR OR RACE: White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): widowed

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
R) WIFE OF ✓

E OF BIRTH (MONTH, DAY AND YEAR) 10/29/1833

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
90	1	17	

UPATION OF DECEASED
) Trade, profession, or
ticular kind of work Retired merchant
) General nature of industry,
siness, or establishment in
ich employed (or employer) .....
Name of employer 131

THPLACE (CITY OR TOWN) .....
TATE OR COUNTRY) Henry Co. Va.

NAME OF FATHER Geo. H. Bassett

BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va.

MAIDEN NAME OF MOTHER Columbia Staples

BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Va.

ORMANT T. G. Bassett
ldress) Paris, Mo.

ED 12/17, 1923. H C Payne REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/16 1923

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Dec 16, 1923 that I last saw him alive on Dec 16, 1923, and that death occurred, on the date stated above, at 5 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial Nephritis resulting from high arterial tension
(duration) 3 yrs. x mos. x ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs

(Signed) H C Payne, M. D

12/17, 1923 (Address) Paris Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Walnut Grove — DATE OF BURIAL: 12/18 1923

20. UNDERTAKER: Fred A. Thompson — ADDRESS: Madison Mo.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and Sta

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED ..... , 19 ....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....
that I last saw h..... alive on....., 19.....
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY .....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) .....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUS
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUIC
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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BU

20. UNDERTAKER	ADDRESS