

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

Do not use this space.

9658

1. PLACE OF DEATH

County Registration District No. 791
 Township Primary Registration District No. 1003
 City St. Louis Mo. (No. 2545 N. University St.) St. Ward)

File No.
 Registered No. 2188

2. FULL NAME

Hariford Bassett
 (a) Residence No. 2545 N. University St. 20 Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1st 1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
87 8 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Carpenter
 (c) Name of employer

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

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

14. INFORMANT Frank Bassett
 (Address) 2545 N. University St.

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1926, to Feb. 2 1927 that I last saw him alive on Feb. 7 4:30 PM 1927 and that death occurred, on the date stated above, at 7:45 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1166 Cancer of the Throat
13144 (duration) yrs. 3 mos. da.
 CONTRIBUTORY Chronic Intestinal
 (SECONDARY) Nephritis (duration) 2 yrs. mos. da.

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? Clinically
 (Signed) E. C. Johnson, M. D.

March 4, 1927 (Address) 4470 Natural Bridge

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Friedens. DATE OF BURIAL Mar 6 1927

20. UNDERTAKER Wey Leidner Und. Co. N. Market St. ADDRESS 1417

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

ALL INFORMATION CALLED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
 Township.....
 City St. Louis (No.....) St..... Ward.....

Registration District No. 791
 Primary Registration District No. 1003

File No.....
 Registered No. 2188

2. FULL NAME

Harford Bassett

(a) Residence. No..... St..... Ward.....
 (Usual place of abode)

(If nonresident give city or town and State)

Length 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

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

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)

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. Maub Starckoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3 1927

17.

I HEREBY CERTIFY, That I attended deceased from

..... to, 19..... that I last saw h..... alive on, 19..... and that death occurred, on the date last above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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)....., M. D. , 19 (Address)

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

N. S. Item of information should be carefully supplied. AGE should be properly classified. DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

92-2021-5