

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

Do not use this space.

*Glover*  
375-81-a

**1. PLACE OF DEATH**

County *Miller*  
Township *Saline*  
City (No. ....) St. .... Ward (No. ....)

Registration District No. *561*  
Primary Registration District No. *5755a.*

File No. *375-81-a*  
Registered No. *12-13*  
St. .... Ward (No. ....)

**2. FULL NAME**

*Sarah C. Bassett*

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

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female*  
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 *Stephen Bassett*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 26 1848*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *79 10 13*  
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Housewife 167*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Salida*  
(STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *W H Fulbright*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Not known*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *X X*

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

14. INFORMANT *Silva Haynes*  
(Address) *Lafayette MO.*

15. FILED *4-10-28* *Belle Haynes*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-9-1927*

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h. .... alive on ..... 19..... and that death occurred, on the date stated above, at..... *9-10* p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Died Suddenly. No Phys. was called until after death. And the undertaker reported Dr. Glover & Queen was then called.*  
CONTRIBUTORY (SECONDARY) *Old age & debility*

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: *164*

8 DID AN OPERATION PRECEDE DEATH: DATE OF .....

WAS THERE AN AUTOPSY? *164*

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Springfield* DATE OF BURIAL *12/12 1927*

20. UNDERTAKER *W A Rully* ADDRESS *Glover*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. 1928

PARENTS

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