

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

Do not use this space.
14064

23 1929

PLACE OF DEATH

County..... Cape Girardeau Registration District No..... 125
Township..... 4 Primary Registration District No..... 3009
City..... (No.) St. Ward.....

File No.....
Registered No..... 95
St. Ward.....

2. FULL NAME

Wm S Bass

(a) Residence. No. 215 Bellevue 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 6 2

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Samuel Bass

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

12. MAIDEN NAME OF MOTHER Julia Bass

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

14. INFORMANT Jane E. Bass
(Address) Cape Girardeau

15. FILED 3/8 1929 W.C. Kämpfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7 19 29

17. I HEREBY CERTIFY, That I attended deceased from April 7 19 29
(that I last saw him/her alive on April 7 19 29, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute subdural
hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) H. J. Chrostic M. D.

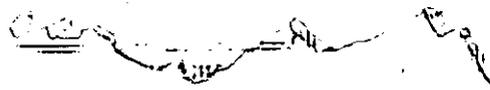
, 19 (Address) Cape Girardeau Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview Cem DATE OF BURIAL Apr 8 1929

20. UNDERTAKER Walther Und. Co. Cape Gir. Mo. ADDRESS

2-5-29



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**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 Cape Gir

Registration District No. 123-

File No. _____

Township _____

Primary Registration District No. 3009

Registered No. 92-

City _____ (No. _____)

St. _____ Ward _____

2. FULL NAME

Wm S Bass

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)

M

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

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

Oct 5 - 1873

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

55

6

2

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

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

Apr 7 1929

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute indigestion
from improper meals

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

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) H. C. ... 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

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

14. INFORMANT _____

(Address)

15.

FILED 6/13 1929 W. H. ... REGISTRAR

SUPPLEMENTARY

... CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SECRETARY OF THE ARMY

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

ATTENTION: [illegible]

DATE: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

S-14064