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

Do not use this space.

33166

1. PLACE OF DEATH
County Cape Girardeau — Registration District No. 124 — File No.
Township Byrd — Primary Registration District No. 4070 — Registered No. 46
City Jackson (No. ..... St. ..... Ward)

2. FULL NAME Ben E. Masters
(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: 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 Bertha Heunnecke Masters

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 22 1870.

7. AGE: Years 59 — Months 1 — Days 9 — If LESS than 1 day, ..... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Christopher Masters
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Sedgwicksville Mo
12. MAIDEN NAME OF MOTHER Seabaugh
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo Kinsman

14. INFORMANT Mrs. Ben Masters
(Address) Jackson Mo.

15. FILED 4-1, 1929 D. G. Sieber
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 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 1/0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral appoplexy
82 A
74 A
(duration) ..... yrs. ..... mos. ..... ds.

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) Chas. D. Jaeger M.D.
10-31, 1929 (Address) Coroner

*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: City Cemetery Jackson — DATE OF BURIAL: Nov 2 1929

20. UNDERTAKER: McCombs Funn & Ward Co. — ADDRESS: Jackson Mo.

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.