

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

Do not use this space.

28894

1. PLACE OF DEATH

County Sullivan
Township Pock
City Near Milan (No. _____)

Registration District No. 852
Primary Registration District No. 6120

File No. _____
Registered No. 31
St. _____ Ward _____

2. FULL NAME

Leish Fuller Bausell

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 10 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 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 Mary Francis Bausell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 1 25

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Sullivan Co.
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Calvin Bausell

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

12. MAIDEN NAME OF MOTHER Nancy Fuller

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

14. INFORMANT Shack Bausell
(Address) Milan, Mo.

15. FILED 8-7-30 Bertha McClary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 3, 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-29, 1930, at 3 o'clock, and that I last saw him alive on 8-2, 1930, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infection of the Prostate Gland and Asthma, 3 weeks
137 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 112 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 135
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Ross H. Shepler, M. D.

Aug 4, 1930 (Address) Green City, 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 near DATE OF BURIAL Aug 4, 1930

20. UNDERTAKER Knitting Green Browning ADDRESS Milan, Mo.
C. A. Schoore

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.

AUG 26 1930

