

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25086**
Registrar's No. **5672**

FILED JUL 24 1944

Registration District No. **1**

Primary Registration District No. **5672**

1. PLACE OF DEATH:

- (a) County **LINCOLN**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. **1** (Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME **EXTON ELY BASS**

3. (b) If veteran, name war. **10** 3. (c) Social Security No. **2**

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife: **2** 6. (c) Age of husband or wife if alive **29** years

7. Birth date of deceased **OCT 29 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 8 13 hr. min.

9. Birthplace **Booneville Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **ELY BASS**
13. Birthplace **UNKNOWN** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **11** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Elsie Harrel**

- (b) Address **Briscoe Mo**

17. (a) **Burial** (b) Date thereof **July 13-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **Asbury Cemetery**

18. (a) Signature of funeral director **Chas. H. H. H.**

- (b) Address **Elsbey, Mo**

19. (a) **7-13-44** (b) **Mrs. Susan Herson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **Lincoln**
(c) City or town **Rural** **57**
(If outside city or town limits, write "RURAL")

- (d) Street No. **0** (If rural, give location)

- (e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13**
year **1944** hour **1** minute **15** M.

21. I hereby certify that I attended the deceased from **July 13** to **July 13**, 19 **44**
that I last saw him alive on **July 13** and that death occurred on the day and hour stated above.

- Immediate cause of death **Cerebral apoplexy 4 day**

- Due to **Generalized arteriosclerosis**

- Due to **Demility**

- Other conditions (Include pregnancy within 3 months of death)

- Major findings: Of operations **83a**

- Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)

- (b) Date of occurrence

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? (Specify type of place) (Mean of injury)

23. Signature **Joe. Lebrach** (Date of death) **July 13/44**

- Address **Troy**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-21-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

July 11-1944, Registered Apprentice No.
working under my personal supervision.

Signed.....

Clifton Miller

Licensed Embalmer No. 3364

P. O. Address.....

Elberry Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.