

pt. Health,
& Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43495
STATE FILE NUMBER

FILED JAN 6 1958

Registration District No. 38 Primary Registration District No. 5118 Registrar's No. 475

S. 300
ev. 1-57/

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia Mo, TWP		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Columbia 0160 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R.F.D. 3		Length of stay in 1b 15 1/2	d. STREET ADDRESS (If outside, give location) R.F.D. 3 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LUTHER BASS			4. DATE OF DEATH Month Day Year 12 / 26 / 57	
--------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--

5. SEX Male	6. COLOR OR RACE negr	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28 - 1886	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
--------------------	------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------	----------------------------------------------	-------------------------------------------	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Deer Park Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--------------------------------------------------------------------------------------------------------------	-----------------------------------	--------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME Henry Bass	13b. MOTHER'S MAIDEN NAME Luan Stennons	14. NAME OF HUSBAND OR WIFE Aula Bass
-----------------------------------------	---------------------------------------------------	-------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Lula Buckner, Columbia, Mo. Address
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	----------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion - Chronic Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH Seconds 3-3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from **Coronels Care** and last saw her alive on _____ m on the _____ date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm. H. Neal M.D.	22b. ADDRESS Columbia Mo.	22c. DATE SIGNED 12/29/57
-------------------------------------------------------------	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 30, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) Columbia, Mo.
------------------------------------------------------------	-----------------------------------	------------------------------------------------------	-----------------------------------------------------------------------

24. FUNERAL DIRECTOR Mrs. Stuart Parker, Columbia, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Dec. 30, 1957	26. REGISTRAR'S SIGNATURE Mrs. R. E. Palmer
------------------------------------------------------------------	---------	------------------------------------------------------	-------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Gayle Green*

Licensed Embalmer No. *4220*

P. O. Address *Marshall, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.