Health, & Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004276

STATE FILE NUMBER

FILED JAN 7 1959 Registration District No. 366 Primary Registration District No. 4536 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Potosi — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 206 W. Bretton — Length of stay in 1b 9 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Washington
c. CITY OR TOWN Potosi — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 206 W. Bretton — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First John Middle David Last Bass

4. DATE OF DEATH Month Jan. Day 5 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb. 9 1874
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months 10 Days 26 — IF UNDER 24 HRS. Hours Min.

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) Washington Co Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Bass
13b. MOTHER'S MAIDEN NAME Squilla Benson
14. NAME OF HUSBAND OR WIFE Nora Bass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Nora Bass Address Potosi Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis
DUE TO (c) Arthritis Osteo
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Dec. 10, 1958 to Jan 5, 1959 and last saw him alive on Dec 29/58
Death occurred at 1400 h m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G. F. Cruswell MD
22b. ADDRESS Potosi, Mo.
22c. DATE SIGNED 1/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-7-59
23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery
23d. LOCATION (City, town, or county) (State) Potosi Mo.

24. FUNERAL DIRECTOR Mrs Luther Sparks ADDRESS Potosi Mo.
25. DATE REC'D. BY LOCAL REG. 1/6/59
26. REGISTRAR'S SIGNATURE Herbert Kendall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

RECEIVED

JAN 6

WASH. COUNTY HEALTH DEPT.

File No. _____

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 Murphy L Spurlock .....

Licensed Embalmer No. 4236 .....

P. O. Address Flat River 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.