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

V. S. NO. 2.

1. PLACE OF DEATH
35 County Dunklin Registration District No. 289 File No. 39134
8 Township Cotton Hill Primary Registration District No. 4173 Registered No.
6 City Malden (No. ... St. ... Ward)

2. FULL NAME Charles Hill Bastic

(a) Residence. No. ... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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 Mary Elouise Bastic

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 5 - 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
73	8	24	

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

9. BIRTHPLACE (CITY OR TOWN) Lawrenceburg Ind.
(STATE OR COUNTRY) 2

10. NAME OF FATHER John D. Bastic

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lawrenceburg
(STATE OR COUNTRY) Ind.

12. MAIDEN NAME OF MOTHER Marth Langdale

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

14. INFORMANT Mrs C H. Bastic
(Address) Malden, Mo

15. FILED 1-1 1933 Homer Beall (M D) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1932

17. I HEREBY CERTIFY, That I attended deceased from Nov 21st, 1932, to Dec. 29, 1932, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 9:30 - P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
920
115
(duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Influenza Nov 21 to 26 th 1932
(duration) ... yrs. ... mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
8 WAS THERE AN AUTOPSY? ... (1)
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John Van Cleve, M. D.
, 19 ... (Address) Malden 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 Malden, Mo DATE OF BURIAL Jan. 1 1932

20. UNDERTAKER W. L. Craig ADDRESS Malden

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ... St. .....Ward)

2. FULL NAME.....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19....
that I last saw h..... alive on....., 19....., and th
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.....

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)....., M.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, st
(1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL
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20. UNDERTAKER	ADDRESS

U. S. No. 2.