AUG 20 1930

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

22095

V. S. No. 2.

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.

1. PLACE OF DEATH
County Caldwell
Township Lincoln
City ..... (No. ....., ... St. ..... Ward)
Registration District No. 95
Primary Registration District No. 5-141
File No. 8
Registered No. 8

2. FULL NAME Hilda Genevieve Basham
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ——

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 25-1917

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
12	7	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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) Ray, Co, Mo

PARENTS

10. NAME OF FATHER Clarence R. Basham
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ray Co., Mo.
12. MAIDEN NAME OF MOTHER Maggie Maude Michael
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Caldwell Co., Mo

14. INFORMANT Clarence R Basham
(Address) Cowgill Mo.

15. FILED 7/14 1930 G. B. Conley WR REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1930

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 13, 1930, that I last saw her alive on July 8, 1930, and that death occurred, on the date stated above, at 8 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Middle ear abscess
894
85
(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Epilepsy Grand mal
(duration) 10 yrs. ..... mos. ..... ds.

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? .....

7/14 (Signed) O. C. Kilbourn, M. D
1930 (Address) Cowgill, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cowgill Mo.
DATE OF BURIAL: 7-14. 1930

20. UNDERTAKER: C. A. Reed, Cowgill, Mo.
ADDRESS

V. S. No. 2.

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

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 .....
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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

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19....
that I last saw h..... alive on....., 19....., and
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, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS