

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

Do not use this space.

20871

File No. _____
Registered No. 130
St. _____ Ward)

PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township _____ Primary Registration District No. 3009
City _____ (No. _____)

2. FULL NAME

Ben Bash
(a) Residence No. R. D. # 2 St. Francis Hospital 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 21 - 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 4 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cape Girardeau, County
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER B. B. Bash

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cape County, Mo
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Martha Perry

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

14. INFORMANT Mrs. Albert Hama
(Address) R. D. # 2

15. FILED 6/4, 19 29 W. C. Temple REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3 19 29

17. I HEREBY CERTIFY, That I attended deceased from 5-4-29 to 6-3-29
that I last saw him alive on 6-3-29 at 3 P.M. and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Cardiac Valvular Dis.
115/115 (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Tonsillitis (duration) 2 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF 6-5-29

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) _____ M. D.

*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 Parment. DATE OF BURIAL June 5 19 29

20. UNDERTAKER W. C. Temple ADDRESS 536 Parkland

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.

24-1929

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8

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