

REC'D MAR 20 1938

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

7131
Do not use this space.

1. PLACE OF DEATH

(a) County Mason Registration District No. 5-31
(b) Township Whit Primary Registration District No. 5-709
(c) City Ethel (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
512 Sarah Jane Combs
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 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 S. L. Combs

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 11 - 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 4 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME Chas Mason

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Lucinda Robinson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) S. L. Combs

18. BURIAL, CREMATION, OR REMOVAL PLACE Nathan DATE Dec 19 1938

19. FUNERAL DIRECTOR (ADDRESS) Henry C. Fleming

20. FILED Dec 19 1938 J. P. Shaeffer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-1938 12-16 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 10 1938, to Dec 16 1938.
I last saw him alive on Dec 16 1938. Death is said to have occurred on the date stated above, at 1:30 A.M. X
The principal cause of death and related causes of importance were as follows:

Chronic myositis
93C
Other contributory causes of importance: Outbreak of Stomach

Date of onset 1937

Name of operation None Date of _____
What test confirmed diagnosis? Obit Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) C. A. West, M. D.
(Address) New American Inc

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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RECEIVED

District Health Officer No. 10

District File Number 10-39-340

Date Filed MAR-1-3-1939

STATEMENT BY LICENSED EMBALMER

I, Henry C. Young, Licensed Embalmer No. 3902

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Henry C. Young

Licensed Embalmer No. 3902

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.)