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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REC'D JUL 11 1939

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

21600
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan 2 Registration District No. 85

(b) Township 1 Primary Registration District No. 1001 Registered No. 637

(c) or City St. Joseph (d) Street No. En Route to Hospital (St. Joseph's Hosp.)
(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 37 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 200 Oscar Delbert Massa

(a) Residence, No. 108 E. Buffalo St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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: Marget Massa

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 14, 1871.

7. AGE: YEARS 68 | MONTHS 3 | DAYS 10 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. General Labor
10. Date deceased last worked at this occupation (month and year) 1933.
11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown / Iowa.

FATHER
13. NAME: James R. Massa 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown / Indiana

MOTHER
15. MAIDEN NAME: Margaret J. Woods
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown / Indiana

17. INFORMANT (ADDRESS): Mrs. Marget Massa, Lincoln, Nebraska

18. BURIAL, CREMATION, OR REMOVAL: Memorial Park Cem.
PLACE St. Joseph, Mo. DATE June 27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): H. O. Sidenfaden & Son, 1802 Union Str. St. Joseph, Mo.

20. FILED June 26, 1939 H. J. Nestlebach, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24, 1939

22. I HEREBY CERTIFY, That I ~~attended~~ VIEWED deceased from 6-24, 1939, to ....., 19....
I ~~last saw h.....alive on~~ ....., 19..... Death is said to have occurred on the date stated above, at 10:30 AM
The principal cause of death and related causes of importance were as follows:

Injuries Received when struck by an auto as a pedestrian

Date of onset

Other contributory causes of importance: None

210 M 21

Name of operation ..... Date of .....
What test confirmed diagnosis? History Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 6/24, 1939
Where did injury occur? St Joseph Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. public place
Manner of injury struck by auto
Nature of injury Fractured skull

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) B. W. Tadlock Coroner M. D.
(Address) King Hill Bldg

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robert P. Clarkson

Licensed Embalmer No. 4028

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.