

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
FIRM DESLOGE
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME Masson Robert

3. (b) If veteran, name war NO 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JUNE 22 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 18 If less than one day hr. _____ min. _____

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation MONUMENT WORKER.

11. Industry or business OWNER.

12. Name WM. MASSON

18. Birthplace MO.
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET SHANNEN

15. Birthplace MO.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Margaret Masson

(b) Address 2848 Henrietta St

17. (a) BURIAL (b) Date thereof SEPT 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MIDDLEBROOK MO

18. (a) Signature of funeral director E. J. Schurr

(b) Address 3125 Lafayette Ave

19. (a) SEP 10 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 23
(If outside city or town limits, write "RURAL")
(d) Street No. 2848 HENRIETTA ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 9
year 1940 hour 7:25 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 9-7-40
_____, 19____, to 9-9-40, 19____;
that I last saw her alive on 4/9/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Wrenia
Our doctor saw her renal disease

Due to _____

Due to 131

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations X

Of autopsy X

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. O. Mueller (M. D. or other) [Signature]

Address 3712 Washington Date signed 9/10/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

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..... *Joe Wollmer*.....
Licensed Embalmer No. *4014*.....
P. O. Address. *3125 Lafayette*.....

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.)

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