

FILED DEC 1 1942 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 9822

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 Days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **William F. Mason**

3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Theresa Mason** 6. (c) Age of husband or wife if alive **20** years **1866**

7. Birth date of deceased **February** (Month) **20** (Day) **1866** (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	9	2 hr. min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Wash-House Attendant**

11. Industry or business.....

MOTHER FATHER

12. Name **John Mason**

13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Florence Bullion**

15. Birthplace **West Va.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Charlotte Schulz**

(b) Address **6043 Garasche**

17. (a) **Burial** (b) Date thereof **11-25-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge**

19. (a) **NOV 22 1942** (b) **J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **6043 Garasche**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **22**, year **1942** hour **11:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **November 16**, 19 **42** to **November 22**, 19 **42** that I last saw him alive on **November 22**, 19 **42** and that death occurred on the date and hour stated above.

Immediate cause of death:
Brain abscess secondary to generalized atherosclerosis
 Due to.....
 Due to.....
 Other conditions **carcinoma of caecum**
(Include pregnancy within 3 months of death)
Hypertrophy of prostate
 Major findings:
 Of operations.....
 Of autopsy **as above**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 **J. Bredeck** (M.D. or other).....
 Address **1515 Lafayette Avenue**, Date **11/23/42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Sheldon Callier
Licensed Embalmer No. 3382
P. O. Address.....

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, fact should be so stated above.