

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
 (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 Childrens Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **JUDITH Evelyn Mason**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **Nil**

4. Sex **Female** 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 **September 21 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 hr. min.

9. Birthplace **Frank Clay Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Melvin Mason**

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

14. Maiden name **Margaret Bowen**

15. Birthplace **Unavailable Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Melvin Mason**

(b) Address **Frank Clay, Missouri**

17. (a) **Burial** (b) Date thereof **10/25/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Frank Clay, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **OCT 29 1943** (b) **J. P. Bredich**
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22**
 year **1943** hour **5** minute **30A** M.

21. I hereby certify that I attended the deceased from **October 18th**, 19**43** to **October 22**, 19**43**
 that I last saw her alive on **October 21**, 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Peritoneal Abscess of Intestine**
Sec. Sapp. Cholelithiasis

Due to _____

Due to _____

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

Major findings:
 Of operations _____
 Of autopsy _____

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. Blather** (M. D. or other) _____
 Address **500 W. Key Highway** Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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.....

John G. Gorski

Licensed Embalmer No. *3348*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registrar's No. 9337

Registration District No. _____

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 St. Louis Children Hospital
(If not in hospital or institution, write street number or location)
 - (d) Length of stay: In hospital or institution _____
(Specify whether)
- In this community _____
years, months or days

- 3. (a) PRINT FULL NAME Judith Evelyn Mason
- 3. (b) If veteran, name war _____
- 3. (c) Social Security No. _____

- 4. Sex _____
- 5. Color or race _____
- 6. (a) Single, widowed, married, divorced _____
- 6. (b) Name of husband or wife _____
- 6. (c) Age of husband or wife if alive _____ year
- 7. Birth date of deceased (August) 21 1943
(Month) (Day) (Year)

- 8. AGE: Years _____ Months (2) Days 1 If less than one day _____ min.

- 9. Birthplace _____
(City, town, or county) (State or foreign country)

- 10. Usual occupation _____

- 11. Industry or business _____

- 12. Name _____
- 13. Birthplace _____
(City, town, or county) (State or foreign country)
- 14. Maiden name _____
- 15. Birthplace _____
(City, town, or county) (State or foreign country)

- 16. (a) Informant _____

- (b) Address _____

- 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

- 18. (a) Signature of funeral director _____

- (b) Address _____

- 19. (a) NOV 1 1943 J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month Oct. day 22
year 1943 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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