. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 29 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35299

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2173

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-1/2 Hrs. (Specify whether
In this community 5-1/2 hrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County Jefferson
(c) City or town Louisville
(If outside city or town limits, write "RURAL")
(d) Street No. 116 S. 39th. St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Kendon D ru Masterson

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

4. Sex F 1 5. Color or race White 6. (a) Single, widowed, married, divorced infant

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

7. Birth date of deceased July (Month) 23 (Day) 1943 (Year)

8. AGE:

Years	Months	Days	If less than one day
1	3	1	12 hr. 30 min.

9. Birthplace Louisville, Ky. (City, town, or county) 1 (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Kenneth L. Masterson
13. Birthplace Louisville, Ky. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Mary Donna Fitzgerald
15. Birthplace Louisville, Ky. (City, town, or county) 1 (State or foreign country)

16. (a) Informant Mrs. K. L. Masterson
(b) Address 116 S. 39th. Louisville, Ky.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Oct. 28-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Louisville, Ky.

18. (a) Signature of funeral director Watson-Booklage
(b) Address 6536 Clayton Rd.

19. (a) OCT 26 1944 (Date received local registrar) (b) E. G. McGavran M.D. (Registrar's signature) Tenn

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 25, 1944 to Oct 25, 1944;
that I last saw her alive on 12:30 p.m., 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis c̄ Congestion of lungs — Duration 16 hrs.
Due to
Due to 6
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Possible Rt adrenal gland hemorrhage - Meningitis

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

23. Signature Jackson Eto (M. D. or other) MD
Address 6420 Clayton Rd St Louis Date signed 10/25/44

107 (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 Albert G. Hoppe

Licensed Embalmer No. 2971

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.