

No. 2
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-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3266

FILED JAN 28 1946

State File No. _____

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural Hudson, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Still Childreth Polioepidemic Sanatorium
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61

(c) City or town Callao Rural 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JAMES MASON

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 25, year 1945 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from 12-9-45, 19____, to 12-25/45, 19____; that I last saw him alive on _____, 1945; and that death occurred on the date and hour stated above.

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 2 - 19 - 1951
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis and myocardial degeneration

Duration Several years

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

94 10 6 - hr. - min.

Due to Senility + arteriosclerosis

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

Major findings: Of operations _____

Of autopsy aut

9. Birthplace Callapepper Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Mason

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

14. Maiden name Margaret Alice Wright

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

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) (Specify means of injury)

16. (a) Informant Mrs. Joe M. Hummer

(b) Address Callao Mo

17. (a) Burial (b) Date thereof 12-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Callao Mo

18. (a) Signature of funeral director J. V. Edwards

(b) Address Callao Mo

19. (a) Jan 21 1946 (b) Ruth Mcneely
(Date received local registrar) (Registrar's signature)

23. Signature Philip B. Lindergerst, D.O. (M.D. or other)

Address Callao, Mo. Date signed 12-

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

100590

RECEIVED

District Health Officer No. 10

District File Number 1-46-153

Date Filed JAN 24 1946

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

W. E. Edward

Licensed Embalmer No. 1961

P. O. Address. B. Lewis Mo

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.