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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 26 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **113687**

Registration District No. **293**

Primary Registration District No. **6005**

Registrar's No. **7**

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

1. PLACE OF DEATH:

(a) County **Ralls**

(b) City or town **New London**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Rall 87**

(c) City or town **New London**
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Ammanda Mason**

3. (b) If veteran, name war **2**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11th**
year **1948** hour **11:30** minute **9** A.M.

4. Sex **Female** 5. Color or race **Negro**

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 **1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **no medical attention**
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

8. AGE: Years **about 80** Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death **accidental death caused from 1st Degree Burns** Duration _____

Due to **received laceration in home - home - home**

Due to **accidentally burned. T. Ammanda Mason**

Other conditions **trapped in fire**
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Home wife**

Major findings: Of operations _____

Of autopsy **18/1**

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

11. Industry or business _____

MOTHER FATHER { 12. Name **no record**

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

14. Maiden name _____

15. Birthplace **no record 9**
(City, town, or county) (State or foreign country)

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

(c) Accident, suicide, or homicide (specify) **Accident 87**

(b) Date of occurrence **3/11/48**

(c) Where did injury occur? **Ralls, Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**
(Specify type of place)

16. (a) Informant **Nellie Bradshaw**

(b) Address **New London, Mo**

17. (a) **Burial** (b) Date thereof **3-13-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New London**

18. (a) Signature of funeral director **Geo E Roberts**

(b) Address **Harrison Mo**

19. (a) **3-15-48** (b) **H. W. Maus 18**
(Date received local registrar) (Registrar's signature)

While at work? **Home** (c) Means of injury **Burns 3**

23. Signature **Plyden W. Crum** (M. D. or other) _____

Address **Berby, Mo** Date signed **3/24/48**

MAY 23 1956

APR 26 1948

RECEIVED
District Health Officer No. 10
District File Number 4-48744
Date Filed APR 23 1948

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 Geo E Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 2

Registration District No. 293 Primary Registration District No. 6005

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town New London
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls
(c) City or town New London
(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 _____

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: all 80 Years Months Days If less than one day hr. min.

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

10. Usual occupation Surgeon

11. Industry or business _____
12. Name No record
13. Birthplace Paris Mo
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Willie Bradshaw
(b) Address New London Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-48
(Month) (Day) (Year)
(c) Place: burial or cremation New London, Mo

18. (a) Signature of funeral director Geo E Roberts
(b) Address Hannibal Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May Year 1948 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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) (c) 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.

S-13687