

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031416

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1017 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 28 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 4 months	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2506 Cypress
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Tenna Middle Mason Last Mason			4. DATE OF DEATH Month Aug. Day 26 Year 1963		
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5. SEX Female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1895	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months 6 Days 16 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Manford Seabolt	13b. MOTHER'S MAIDEN NAME Katherine Woods	14. NAME OF HUSBAND OR WIFE Horace S. Mason
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT State Hospital #2 Records St. Joseph, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 16 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic congestive failure		unknown
DUE TO (c) Coronary arteriosclerosis and myocardial infarction		unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic decubitus ulcers		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour 11 a.m. 11 p.m.	Month, Day, Year 8/26/63
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Joseph, Mo.	COUNTY Jackson	STATE Missouri
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21. I attended the deceased from **3-31-61** to **8/26/63** and last saw her alive on **8/26/63**
Death occurred at **8/26/63 11 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charon M. Clark M.D.	22b. ADDRESS State Hosp #2 St Joseph Mo	22c. DATE SIGNED 8-27-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 27, 1963	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Harp & Sons	ADDRESS 4707 Truman Rd. K.C., Mo.	25. DATE RECD. BY LOCAL REG. Aug 27, 1963	26. REGISTRAR'S SIGNATURE Wm Clark Goodell
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VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **C.M. Clark, M.D.** MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 8-27-63

1054

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 _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed James W. Corpz

Licensed Embalmer No. 4622

P. O. Address H.C., 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 embalmed by a "STUDENT," he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.