

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1727

1. PLACE OF DEATH
 County Livingston Registration District No. 508
 Township _____ Primary Registration District No. 3026
 City Chillicothe (No. _____) St. _____ Ward _____

2. FULL NAME Peggy Jo Ann Mason
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED ✓ (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 27

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Chillicothe Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER A. G. Mason Jr

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Davis Co Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Dorothy Barnes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chillicothe
 (STATE OR COUNTRY)

14. INFORMANT A. G. Mason
 (Address) Chillicothe Mo

15. FILED 1-28, 1927 Rubens Barney
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 26 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 22 1927 to Jan 26 1927
 that I last saw him alive on Jan 25 1927, and that death occurred, on the date stated above, at 2.5 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital heart disease

1570 (duration) yrs. mos. ds. 4
 CONTRIBUTORY (SECONDARY) 15913 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) A. Collier, M. D.

Jan 27, 1927 (Address) Chillicothe Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Park Cem. DATE OF BURIAL 1-27 1927

20. UNDERTAKER FB Norman Chillicothe ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. FEB 26 1927

