

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

Do not use this space.

5431

MAR 23 1928

1. PLACE OF DEATH

County Warren
Township Warrenton
No. RT #6 (No. _____)

Registration District No. 431
Primary Registration District No. 3020
5-5-28

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Clara C. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jacob Reichle
Living & Mason

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-29-1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 4 25

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER Jacob Reichle

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Reichle

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

14. INFORMANT Clara C. Mason
(Address) Warrenton, Mo.

15. FILED 2-25-28 Wm R. Patterson
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1928

17. I HEREBY CERTIFY That I attended deceased from Feb 14, 1928, to Feb 24, 1928.
that I last saw her alive on Feb 22, 1928, and that death occurred, on the date stated above, at 3 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Labor Pneumonia
59
108
(duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY Deabetes Mellitus
(SECONDARY)
(duration) 5 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) John L. Linton, M. D.
, 19 _____ (Address) Linton

*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 Luttrell Cemetery DATE OF BURIAL 2-25-1928

20. UNDERTAKER Stigoney-Core ADDRESS Warrenton Mo

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.

PERMANENT RECORD

