

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

Do not use this space.

26454

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

Primary Registration District No. 1001

City St. Joseph, Mo.

(No. 501 Virginia)

File No. _____

Registered No. 928

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 501 Virginia St. _____

(Usual place of abode)

Ward _____ (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)

Married

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

W. E. Mason

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

Sept. 24, 1859

7. AGE

68

YEARS

10

MONTHS

8

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unknown Illinois

(STATE OR COUNTRY)

10. NAME OF FATHER

A. Easter

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

14. INFORMANT

W. E. Mason

(Address)

501 Virginia

15. FILED

4 1928

John G. [Signature]
 REGISTERAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 2 1928

17. I HEREBY CERTIFY That I attended deceased from 12:19, 1928, to 8/2, 1928, that I last saw her alive on 8/2, 1928, and that death occurred, on the date stated above, at 11:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
59 (duration) yrs. mos. ds. 2

CONTRIBUTORY (SECONDARY) Diabetes Mellitus
57 (duration) yrs. mos. ds. 9

18. WHEN WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? No
 DATE OF OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Dr. [Signature], M. D.
8/3, 1928 (Address) 108 1/2 W. Mo. Ave.

*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 | **DATE OF BURIAL**

Camp Ground Cemetery | August 4, 1928
20. UNDERTAKER | **ADDRESS**

Elleman Funeral Home | 1208 Francis

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.

SEP 24 1928

