

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

Do not use this space.

26743
File No. _____
Registered No. 50
St. _____ Ward _____

1. PLACE OF DEATH

County Chariton
Township Salisbury mo
City _____ (No. _____)

Registration District No. 175
Primary Registration District No. 5243

2. FULL NAME

C. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20 - 1851

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	77	5	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER

John Mason

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER

Lucinda Phelps

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14.

INFORMANT Mrs. C. C. Mason
(Address) Salisbury Mo

15.

FILED 9/10 1928 W. H. Stowling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 - 23 1928

17. I HEREBY CERTIFY, That I attended deceased from August 6 1928, to Aug 21 1928, that I last saw him alive on Aug 21 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ascaris; Stasis pneumonia; Hypostatic
131
1070
1125 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) William W. Fellows, M. D.
8/23 1928 (Address) Salisbury 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

Salisbury Mo 8-24 1928

20. UNDERTAKER

Winkelmejer Bros Salisbury Mo

K. 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.

[The main body of the document contains several paragraphs of text that are almost entirely illegible due to extreme fading and noise. Only a few faint words and symbols are visible, such as "SECRET" and "NOV 1954" at the top, and some scattered characters like "3" and "4" in the lower right quadrant.]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Chariton Registration District No. 175- File No.
 Township Salisbury Primary Registration District No. 5243 Registered No. 50
 City (No.) St. Ward)

2. FULL NAME C. E. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23-1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia - Pneumonia
hypostatic
Broncho Pneumonia
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic nephritis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? 129a DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) M. D.
 , 19 (Address)

SUPPLEMENTARY

14. INFORMANT (Address)

15. FILED 10/9 1928 W. C. Lewis REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 19

20. UNDERTAKER 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-26743