WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

30692

**1. PLACE OF DEATH**

County: Jackson — Registration District No.: 399 — File No.: [illegible]

Township: Kaw — Primary Registration District No.: 1002 — Registered No.: [illegible]

City: Kansas City (No. ..... St Marys Hosp. ..... St. ..... Ward)

**2. FULL NAME** James Franklin Mason

(a) Residence. No. De Soto Kas. St., ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Arra M Mason

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan-14-1865

7. AGE: Years 63 | Months 8 | Days 13 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): Owner.
(c) Name of employer: Self

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

PARENTS
10. NAME OF FATHER: Jno. H. Mason
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky
12. MAIDEN NAME OF MOTHER: M. Nelson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

14. INFORMANT: R. A. Mason
(Address): Mt Sterling Kty

15. FILED 9/27, 1928 M. M. Crowe REGISTRAR
Assn.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept-27 1928

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1928, to Sept 26, 1928, that I last saw him alive on Sept 26, 1928, and that death occurred, on the date stated above, at Sept 27 5 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis —
Hemiplegia
82D cause unknown
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 75 A
(duration) ..... yrs. 1 mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Clarence S Capell M. D
9/27, 1928 (Address) 1135 Thalia KCMo

*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: De Soto Kansas. — DATE OF BURIAL: Sep. 29 1928

20. UNDERTAKER: E. E. Baker — ADDRESS: De Soto Ks