

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

Do not use this space.

1050

21 1929

1. PLACE OF DEATH

County... *Clatsop*
Township... *Washington*
City... *King City, Mo.*

Registration District No. *312*
Primary Registration District No. *4188*

File No.
Registered No. *1*
St. Ward)

2. FULL NAME

Hazel Jean Mass
(a) Residence, No. *King City* St., Ward.
(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 *fr* 4. COLOR OR RACE *no* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 8 1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>2</i>		<i>4</i>	<i>4</i>	

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) *King City Mo*

10. NAME OF FATHER *Henry J. Mass*

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

12. MAIDEN NAME OF MOTHER *Eva McCarthy*

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

14. INFORMANT *H. J. Mass*
(Address) *King City*

15. FILED *Jan 14 1929* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan - 12 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 10*, 1929, to *Jan 12*, 1929 that I last saw her alive on *Jan 12*, 1929, and that death occurred, on the date stated above, at *11 P* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

influenza
(duration) yrs. mos. ds. *8*
1070
81A
CONTRIBUTORY *Bronchial Pneumonia also*
(SECONDARY)
Cerebrospinal invasion.
(duration) yrs. mos. ds. *3*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Richard H. Bennett*

Jan 13 1929 (Address) *King City 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 *King City Mo* DATE OF BURIAL *1-12-29*

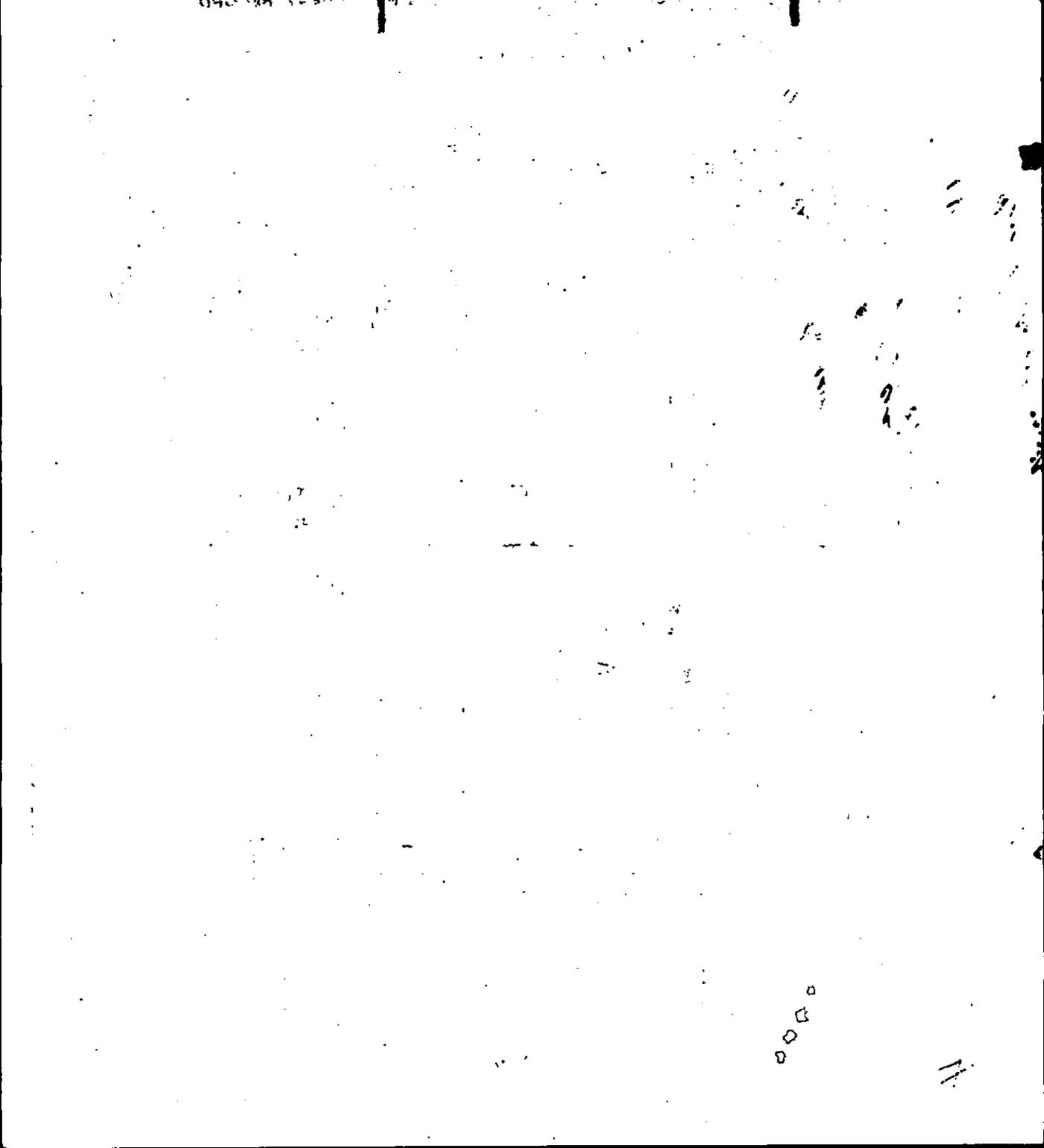
20. UNDERTAKER *R. J. Taggart* ADDRESS *King City*

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.

21 38 5 6

1 2 2



Concerning Death Certificate enclosed. Will say this was not
Cerebrisl Spinal Menengitis but Influenza, nervous type which
developed symptoms of Meningeal invasion.

P. H. Hunt

1929

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**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 Leitner Registration District No. 312 File No. 1
 Township _____ Primary Registration District No. 4188 Registered No. _____
 City King Jay (No. _____) St. _____ Ward _____

2. FULL NAME Harriet Jean Marr
 (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 SW
 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) _____
 14. INFORMANT (Address) _____
 15. FILED Nov. 9, 1929 Chas. L. Little REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 12, 1929
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 (that I last saw h. _____ since on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza (Nervous type affecting the central nervous system)
 (duration) _____ yrs. _____ mos. 8 ds.
 CONTRIBUTORY (SECONDARY) Bronchial Pneumonia also Cerebrospinal invasion from influenza
 (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? NA
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) R. W. Hurd M.D.
 _____, 19____ (Address) King City, Mo.
 *State the DISEASE CAUSING DEATH, or if death 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 _____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

STATE HEALTH DEPARTMENT, WITH UNPAID INK—THIS IS A PERMANENT RECORD

