

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

Do not use this space.

12108

1. PLACE OF DEATH

County St. Louis

Registration District No. 785

Township

Primary Registration District No. 3037

City Kirkwood (No. South, Kirkwood)

File No. _____

Registered No. 38

St. _____ Ward _____

2. FULL NAME George Mason

(a) Residence No. Kirkwood Mo. 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

col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-10-1879

7. AGE

YEARS 50

MONTHS 2

DAYS -

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

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New Haven
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER MOSIS MASON

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

12. MAIDEN NAME OF MOTHER Mary Dixon

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

PARENTS

14. INFORMANT Jane Mason
(Address) St. Kirkwood Mo.

15. FILED 3/10 1929 C. E. Barnett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1-1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13 Pneumo-pneumonia

107 1/2 (duration) yrs. mos. 14 da.

CONTRIBUTORY (SECONDARY) Industrial Nephritis

(duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? at place of death
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings

(Signed) Arthur W. Mendenhall M. D.

22 - 1929 (Address) Wichita Grove 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 New Haven Mo. DATE OF BURIAL 3-5-1929

20. UNDERTAKER Peoples and Co ADDRESS 3100 Franklin

96 MAR 27 1929 33 EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. THIS STATEMENT MAY BE PROPERLY CLASSIFIED.

100

100

100

100

100

100



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 785-
 Township Keokuk Primary Registration District No. 3097 File No. _____
 City Keokuk (No. _____) St. _____ Ward _____ Registered No. 38

2. FULL NAME George 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 Col 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) 1-10-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
50 1 21

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 3/10/29 C. E. Barnett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1-1929

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:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (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? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY CAUSE OF DEATH IN plain terms, so that it may be properly

SUPPLEMENTARY

S-12108