

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

Do not use this space.

3657

File No. _____
Registered No. 8
St. _____ Ward _____

1. PLACE OF DEATH

County Saline Registration District No. 796
Township Marshall Primary Registration District No. 6039
City Camby (No. _____ St. _____ Ward _____)

2. FULL NAME Richard 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Blk 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF infant
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28, 1914
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 1 6

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-13 1930
17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Jan 13, 1930 that I last saw him alive on Jan 8, 1930 and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Contracted Chorea
8 1/2 (duration) yrs. mos. ds.
1570
Postnatal Hemip
(SECONDARY) (duration) yrs. mos. ds.

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 _____

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? Chinese
(Signed) Robert Kennedy M. D.
1/13, 1930 (Address) Marshall Mo

9. BIRTHPLACE (CITY OR TOWN) Saline Co Mo
(STATE OR COUNTRY)
10. NAME OF FATHER Jennie Mason
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Term
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Anna Glenn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mississippi
(STATE OR COUNTRY)

*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.

14. INFORMANT Jayne Mason
(Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Farrow Cem DATE OF BURIAL Jan 13 1930
20. UNDERTAKER Ferguson - William Marshall ADDRESS _____

15. FILED 1-18 1930 Mrs. John M. McGuire REGISTRAR

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.

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