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

Do not use this space.

File No. 6378

Registered No. 1147

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Deaconess Hospital St. ..... Ward)

2. FULL NAME Carrie Mason

(a) Residence. No. 1335 Laurel Ave St., 6. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 10, 1857

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	3	23	

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

PARENTS
10. NAME OF FATHER John Baumann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Unknown

14. INFORMANT Alfred J Mason
(Address) 1335 Laurel Ave

15. FILED Feb 5, 1930 Guy C Hyler REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929 to Feby 2nd, 1930 that I last saw her alive on Feby 1st, 1930 and that death occurred, on the date stated above, at 13:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Bronchial
Hypostatic
107A
169 (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED 1000
IF NOT AT PLACE OF DEATH .....

O DID AN OPERATION PRECEDE DEATH No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Pulmonary symptoms
(Signed) Carl J Rafferty, M. D.
2-3-, 1930 (Address) 414 Wesley Ave Ferguson

*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
Mt Hope Cem	Feb. 4, 1930
20. UNDERTAKER	**ADDRESS**
Drehmann Larral	1905 Union

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.

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Dr. Kontz