SEP 25 1930

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

Do not use this space.

27298

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township Mason — Primary Registration District No. 3079 — Registered No. 213

City Hannibal (No. Levering Hospital St. Ward)

2. FULL NAME Denie Mason

(a) Residence. No. 1217 Lyon 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept-2 1871

7. AGE: Years 58 — Months 11 — Days 14 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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: Joseph Watson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): —

14. INFORMANT: Mrs G. R. Dreden
(Address): Hannibal - Mo

15. FILED Aug 14 1930 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8/16/ 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Aug 16, 1930 that I last saw her alive on Aug 15, 1930, and that death occurred, on the date stated above, at 4-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

[redacted]

Uterine Carcinoma

4 (duration) five yrs. mos. ds.

CONTRIBUTORY (SECONDARY) E

(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) E E Salyer, M. D
, 19 (Address) Hannibal 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: Mt Olivet — DATE OF BURIAL: 8/18 1930

20. UNDERTAKER: James O'Donnell — ADDRESS: Hannibal Mo

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.