

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

Do not use this space.

38513

19-1931

PLACE OF DEATH

County Boone
Township _____
City Centralia (No. _____)

Registration District No. 72
Primary Registration District No. 4041

File No. _____
Registered No. 46
St. _____ Ward _____

2. FULL NAME Placense Benjamin 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 Male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-17-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
47 8 29

8. OCCUPATION OF DECEASED Laborer
(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) Pettis Co.
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Placense Benjamin Mason
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Mary Woods
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

14. INFORMANT Mrs C.B. Mason
(Address) Centralia Mo.

15. FILED 12/18 30 J. J. Harrison
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1930
17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 16, 1930, that I last saw h. _____ alive on Dec 16, 1930, and that death occurred, on the date stated above, at 10:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
11 P
10 P
(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) _____ yrs. _____ mos. 10 ds.

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 General Symp
(Signed) H. S. St. Luke M. D.
Dec 14, 1930 (Address) Centralia 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 Centralia Mo DATE OF BURIAL Dec 19 30

20. UNDERTAKER M. S. McDonald ADDRESS Centralia Mo

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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