

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

Do not use this space.

41386

**1. PLACE OF DEATH**

County.....

Registration District No. 701

Township.....

Primary Registration District No. 1003

City St. Louis, Mo. (No. City Hospital St.                      Ward                     )

File No.                     

Registered No. 12067

**2. FULL NAME** Charles A. Mason

(a) Residence. No. 618 Lami Street St. 23 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

Esther Mason

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5th, 1884

7. AGE

YEARS  
46

MONTHS  
9

DAY  
19

If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

Insurance Agent

(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)

Missouri

10. NAME OF FATHER Thomas Mason

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

Kentucky

12. MAIDEN NAME OF MOTHER Margaret Talbert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

Illinois

14.

INFORMANT.....

(Address) Esther Mason

618 Lami Street

15.

FILED.....

19.....

Wacker-Heldahl  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 24, 1930

17. No Physician in Attendance  
I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19.....  
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 9:30 P..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Endocarditis  
92A

(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 90W

(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? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Fenner, M.D.

12/26/30 (Address) Dep Corvus

\*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

St. Matthews

DATE OF BURIAL

Dec. 27, 1930

20. UNDERTAKER

Wacker-Heldahl

ADDRESS

2331 S. Brdwy.

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.

