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.

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

Do not use this space.

File No. 42576

Registered No. 11718

1. PLACE OF DEATH

County ..... Registration District No. 787

Township ..... Primary Registration District No. ..... (Number)

City St. Louis mo (No. Enroute to City Hospital #2 St. ..... Ward)

2. FULL NAME Bettie Mason

(a) Residence, No. 1707a Goodwin St., 11 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: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE: Years: Abt 62 — Months: ..... Days: ..... If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labor 52

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Nut Factory

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (Years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

FATHER

13. NAME Reace Kimble

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT Della McNairy
(ADDRESS) 1707a Goodwin

18. BURIAL, CREMATION, OR REMOVAL
PLACE Greenwood DATE Dec 31 1932

19. UNDERTAKER R. V. Gibbins
(ADDRESS) 3317 Morgan St

20. FILED DEC 31 1932 19 ..... Marie Stamen Registrar

MEDICAL CERTIFICATE OF DEATH

~~I'm physician in attendance~~

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27 1932

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 6:00 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
9 8 6	
7 8 5	

Other contributory causes of importance:

Name of operation ..... Date of ..... No

What test confirmed diagnosis? ..... Was there an autopsy

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury No Injury

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) J. B. Greene, M. D.

(Address) Deputy Coroner

12/29/32