

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

Do not use this space.

1. PLACE OF DEATH

County _____ Registration District No. _____
 Township _____ Primary Registration District No. _____
 City St. Louis Mo. (No. City Hoop 2) St. _____ Ward _____

42722
 File No. _____
 Registered No. 363

2. FULL NAME

Baby Mason
 (a) Residence, No. 1422 N 11th St., 208 Ward. (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 Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-23-32
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
1

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. nil
 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) St. Louis Mo

FATHER
 13. NAME Edwin Mason

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

MOTHER
 15. MAIDEN NAME Myrtle Griffin

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

17. INFORMANT (ADDRESS) A. Gutjahr, City Hoop 2

18. BURIAL, CREMATION, OR REMOVAL PLACE PCT. 15 FIELD DATE 1-12-1933

19. UNDERTAKER (ADDRESS) 2945 S. 1st

20. FILED JAN 11 1933 City Hoop 2 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-24-1932
 22. I HEREBY CERTIFY, That I attended deceased from 12-23 1932 to 12-24 1932
 I last saw h. h alive on 12-24 1932 Death is said to have occurred on the date stated above, at 10:05 m.
 The principal cause of death and related causes of importance were as follows:

159
Chorea
 Date of onset 7 months
 Other contributory causes of importance: (1)

Name of operation _____ Date of _____
 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 _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Amshush _____, M. D.
 (Address) City Hoop 2

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.

