

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

NOV 19 1934

Do not use this space.

36868

1. PLACE OF DEATH

78 County Boonville Registration District No. 114  
Township Madair Primary Registration District No. 3869  
City Boonville, Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 13

Registered No. \_\_\_\_\_

2. FULL NAME

James Allen Mason  
(a) Residence, No. Postageville, Mo. 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 Wife  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25 - 1934  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
2 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None  
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) New Postageville Mo.  
Boonville Mo.

MOTHER FATHER 13. NAME Frank Kellison Albert Mason

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boonville Mo.

MOTHER 15. MAIDEN NAME Frances Kellison

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

17. INFORMANT Albert Mason  
(ADDRESS) Postageville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hayward DATE 10/15/34

19. UNDERTAKER R. M. Payne  
(ADDRESS) Postageville Mo.

20. FILED 11/16 1934 C. Moore Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 4, 1934

22. I HEREBY CERTIFY, That I attended, deceased from Saw once only in my office 1934

I last saw him alive on Sept. 28, 1934 Death is said to have occurred on the date stated above, at 1 P. m.

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

Malnutrition all life Date of onset \_\_\_\_\_

Other contributory causes of importance: 158

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

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) R. A. Reider, M. D.

(Address) Postageville Mo.

