

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

Do not use this space.

OCT 23 1935

**791
1003**

31028

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis*

(Name of Hospital) *St. Luke's Hospital*

File No.....

7823

Registered No.....

St..... Ward.....

2. FULL NAME

William J. Mason

(a) Residence, No.....

1333 S. Broadway, 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *about 1887*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,
<i>about 48</i>				hrs.
				or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Night Watchman*

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

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.*

13. NAME *John Mason*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

15. MAIDEN NAME *Delia Miller*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

17. INFORMANT (ADDRESS) *Agnes Mansbach*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Calvary* DATE *Sept 19 1935*

19. UNDERTAKER (ADDRESS) *Benedict Weber's 1128 N. 6th St.*

20. FILED *17 1935* 19..... *J.F. Bredeck*
Registrar.

MEDICAL CERTIFICATE OF DEATH

No. City matter of
21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 16, 1935*

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..... P.m.

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

*Chronic Myocarditis
Chronic interstitial nephritis
Arterio Sclerosis*

Date of onset

Other contributory causes of importance:
131

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *Yes*

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) *Harold P. Schuh*, M.D.
(Address) *St. Louis*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. SPK. 2
100M-11-24-33

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.

