

REC'D MAR 13 1939

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

791
10084430
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. **1123**
(c) City **St. Louis** (d) Street No. **Frisco Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

296 William J. Masterson,
(a) Residence, No. **1223 Claytonia Terrace** St. **NR RICHMOND HEIGHTS, Mo.**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 3, 1939** 195A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mary Masterson,**

22. I HEREBY CERTIFY, That I attended deceased from **1/29/39** 19, to **2/3/39** 19.
Last saw him alive on **2/3/39** 19. Death is said to have occurred on the date stated above, at **4:30 A.M.**
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 5, 1893**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
45 5 29

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Asst. Traffic Mgr.**
9. Industry or business in which work was done, as saw mill, bank, etc. **Frisco R.R.**
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

Date of onset

Aneurysm of the cerebral branch of the internal carotid (right) **1/29/39**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

Other contributory causes of importance:
Hypertensive cerebrovascular disease due to degeneration

13. NAME **Thomas J. Masterson**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**15. MAIDEN NAME **Elizabeth Gallagher**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Chicago Illinois**17. INFORMANT (ADDRESS) **Mrs. Mary Masterson, 1223 Claytonia Terrace**18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **2-6-39** 1919. FUNERAL DIRECTOR (NAME) (ADDRESS) **Cullinane Brothers 1710 N. Grand Blvd.**20. FILED **J. B. Brudick Local Registrar.**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) **Arthur C. Saylor** M. D.
(Address) **2960 Laclede**

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.

FEB 3 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

..... or by

Registered Apprentice No., working under my personal supervision.

Signed

Fred Frick

Licensed Embalmer No. 3186

P. O. Address

St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.