

SEP 1 1939

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

29784
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 345
(b) Township Big Grove Primary Registration District No. 5810
(c) City Liberton, Mo. R 3. (d) Street No. _____ 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 Benjamin S. Mason

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 25-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 4 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as 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) Shannonstown Ill

13. NAME Jonathon Mason

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

15. MAIDEN NAME Mary Brann

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

17. INFORMANT (ADDRESS) Mrs. Foster Babcock
Honesboro, Ark.

18. BURIAL, CREMATION, OR REMOVAL PLACE new Madrid, Mo DATE Aug. 17 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Palmer & Blud Co.
new Madrid, Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 15 1939

22. I HEREBY CERTIFY, That attended deceased from Aug 13, 1939, to Aug 15, 1939. I last saw him alive on Aug 15, 1939. Death is said to have occurred on the date stated above, at 5:30 a.m.
The principal cause of death and related causes of importance were as follows:

Acute yellow atrophy of liver Date of onset _____

Other contributory causes of importance: Alcoholic

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) J. P. Waters, M. D.
899 (Address) Liberton, Mo.

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 8/28/39

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 Leo Hedgcock
Licensed Embalmer No. 3803
P. O. Address New Mexico

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29784
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 345
(b) Township Big Prairie Primary Registration District No. 5800
(c) City _____ (d) Street No. _____ Registered No. _____
(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 Benjamin L. Mason

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Mason
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-25-1865
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 4 20
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15-1939
22. I HEREBY CERTIFY, That I attended deceased from Aug 13 5:30 to Aug 15 1:00, 1939
I last saw him alive on Aug 15-1939. Death is said to have occurred on the date stated above, at 5:30 m.
The principal cause of death and related causes of importance were as follows:
acute yellow atrophy of liver Date of onset _____
Other contributory causes of importance: alcoholic

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
13. NAME Jonathan Mason
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
15. MAIDEN NAME Mary Robinson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
17. INFORMANT (ADDRESS) Mrs. Tolson Babers Jonesburg Ark
18. BURIAL, CREMATION, OR REMOVAL PLACE New Madrid Mo DATE 8-17-1939
19. FUNERAL DIRECTOR (ADDRESS) Richardson and Co New Madrid Mo
20. FILED Dec 4 1939 Meduel Deane Local Registrar.

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) J. F. Waters, M. D.
(Address) Director

RECEIVED

District Health Officer No. 2,

District File Number 839-402

Date Filed 8-29