

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

2862
Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. H64
 (b) Township Chapin Primary Registration District No. 4279
 (c) City Wellington (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

FRANKLIN N. MASON
 (a) Residence, No. 119 Olive St. Kansas City Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Geneva Mason</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 10, 1908</u>		
7. AGE YEARS <u>31</u>	MONTHS <u>7</u>	DAY <u>23</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Laborer</u>	11. Total time (years) spent in this occupation <u>Life</u>
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Iron Mine</u>	
	10. Date deceased last worked at this occupation (month and year) <u>Jan 1, 1940</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
FATHER	13. NAME <u>Fred Mason</u>	<u>9</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
MOTHER	15. MAIDEN NAME <u>Bulah Young</u>	<u>0</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Calhoun Mo.</u>	
17. INFORMANT (ADDRESS) <u>Geneva Mason 119 Olive, K. C. Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cedar Summit</u> DATE <u>Jan 5, 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Adams & Sons Wellington Mo.</u>		
20. FILED <u>Jan 9, 1940</u> <u>F. M. Mason</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2, 1940

22. I HEREBY CERTIFY, That I attended deceased from NONE 19__ to __ 19__

I last saw h. m. alive on NO 19__ Death is said to have occurred on the date stated above, at 1230 p.m. Jan 2, 1940

The principal cause of death and related causes of importance were as follows:
Shock following gunshot wound

Other contributory causes of importance:
Skull fracture occipital bone
Exposure - weather

Name of operation _____ Date of _____
 What test confirmed diagnosis? PE Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury Jan 1, 1940
 Where did injury occur? U.S. highway 24 Wellington Mo.
 (Specify city or town, county, and State) Mo.
 Specify whether injury occurred in industry, in home, or in public place.
Public highway

Manner of injury automobile accident
 Nature of injury Skull fracture

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Genevieve Adams, M. D.
 (Address) Wellington, Missouri

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.

4000

710 ml
95

RECEIVED
District Health Officer No. 8
District File Number *12/40*
Date Filed

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 *Roy Ewen*

Licensed Embalmer No. *3076*

P. O. Address *Wellington 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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2862
Do not use this space.

1. PLACE OF DEATH
(a) County Lafayette Registration District No. 466
(b) Township Wellington Primary Registration District No. 4279 Registered No. _____
(c) City Wellington (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 Franklin M. 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 _____

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>31</u>	<u>7</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2, 1940

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 _____ m.
The principal cause of death and related causes of importance were as follows:
Shock following traffic accident
210 mi
Other contributory causes of importance:
COLLISION WITH FIXED OBJECT Jan 2
DITCH OF HIGHWAY 1940

Name of operation None Date of _____
What test confirmed diagnosis? P.E. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ACCIDENT Date of injury Jan 2, 1940
Where did injury occur? 1 MILE WEST WELLINGTON, MO
HIGHWAY U.S. 24 (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
PUBLIC HIGHWAY
Manner of injury DECEASED JUMPED FROM 94 TO
Nature of injury SKULL FRACTURE, SHOCK

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) E. S. Wallace, M.D.
(Address) Keokuk Mo

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

