DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
RECD JUN 22 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18903

Registration District No. 502 | Primary Registration District No. 4305 | Registrar's No. 15

1. PLACE OF DEATH:
(a) County: Linn
(b) City or town: Marceline Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether) In this community 35 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Linn
(c) City or town: Marceline Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 218 W. Lake (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Hubert Reed Mason 204
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Selma C Mason
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Jan. (Month) 21 (Day) 1869 (Year)
8. AGE: Years 71 | Months 3 | Days 22 | If less than one day ____ hr. ____ min.
9. Birthplace: Bureau County (City, town, or county) Ill. (State or foreign country)
10. Usual occupation: Railway Clerk
11. Industry or business: Retired
FATHER
12. Name: John Mason
13. Birthplace: New York (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Helen Rugg
15. Birthplace: New York (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: Walter W. Mason
(b) Address: 117 Stewart, Columbia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 15 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Olivet
18. (a) Signature of funeral director: Jas M. McLaughlin
(b) Address: Marceline Mo
19. (a) 5-15-40 (Date received local registrar) (b) Olive Barnett (Registrar's signature)

~~MEDICAL~~ CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1940 hour 6 minute P.M.
21. I hereby certify that I attended the deceased from April 19 40, 19__, to May 13, 19 40, that I last saw him alive on May 13, 19 40, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic endocarditis	
Due to: Chronic endocarditis	5 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature: L. O. Adamson D.O. (M.D. or other) D.C.
Address: Marceline, Mo Date signed: 5-15-40

(Licensed Embalmer's Statement on Reverse Side)

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 5 1942

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RECEIVED
District Health Officer No. 11,
District File Number 640 - 929
Date Filed JUN 13 1940

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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Marceline Mo

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

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