

JUL 15 1940
Registration District No. 295

Primary Registration District No. 4179

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. Franklin
(b) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None at Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Jesse Green Mason, 250

3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Nancy Mason, 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 11th, 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Davisville, Missouri, (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

FATHER { 12. Name Jesse G. Mason,
13. Birthplace Tenn. (City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Louise Martin, (City, town, or county) (State or foreign country)
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Lula Dace,
(b) Address Berryman, Missouri,

17. (a) Burial (b) Date thereof 6.23.1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berryman, Mo.

18. (a) Signature of funeral director J. S. Williams

(b) Address Succidan, Mo.

19. (a) 6-23-40 (b) C. A. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Sullivan, (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd.
year 1940 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from May 15-1940
June 22, 1940 to June 22, 1940
that I last saw him alive on June 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Duration 5-15-40
66-2246

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

J. F. Williams

Licensed Embalmer No. 427

P. O. Address Sullivan, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21682
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 295

Primary Registration District No. 4179

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

PLACE OF DEATH:
(a) County Franklin
(b) City or town Sullivan
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jesse Green Mason
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 79 Months 9 Days 11 If less than one day, hr. _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-23-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

20. DATE OF DEATH: Month June day 22
year 1940 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from 5-15-40 to 6-22-40
that I last saw him alive on 6-17-40
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Duration 5-15-40

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Sullivan Date signed 6-23-40

SUPPLEMENTARY

MOTHER FATHER

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

