

FILED FEB 18 1941

Registration District No. 849Primary Registration District No. 6123Registrar's No. 11

1. PLACE OF DEATH:

(a) County Sullivan
 (b) City or town Rural--Buchanan Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: XX
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Life 3 mo.
 years, months or days)

3. (a) PRINT FULL NAME Carolyn Sue Mason3. (b) If veteran, name war XX 3. (c) Social Security No. XX4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Oct. 13 1940
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
0 3 4 hr. min.9. Birthplace Sullivan Co. Missouri
(City, town, or county) (State or foreign country)10. Usual occupation XXX11. Industry or business XXX12. Name Ernest Mason13. Birthplace Missouri
(City, town, or county) (State or foreign country)14. Maiden name Hazel King15. Birthplace Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Hazel Mason(b) Address Brush City17. (a) Burial (b) Date thereof Jan 19 1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hawkeye Cem.18. (a) Signature of funeral director Glenn E. Frazier(b) Address Green City, Missouri19. (a) Jan 24 41 (b) Virginia Gibson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan 105-
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18TH
year 1941 hour 3:45 minute 9 M.21. I hereby certify that I attended the deceased from Jan 17
1941 to Jan 18 1941;
that I last saw her alive on Jan 18 1941;
and that death occurred on the date and hour stated above.Immediate cause of death Bronchial Pneumonia 2 days
Duration

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? _____

771 (Specify type of place) _____
While at work? _____ (e) Means of injury _____23. Signature D. E. Osburn (M.D. or other) 3Address Brush City Mo. Date signed 1-18-41By Alma Bonkin (Licensed Embalmer's Statement on Reverse Side)

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

109

RECEIVED

District Health Officer No. 10

District File Number 2-41-208

Date Filed FEB 7 1941

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.....

was not embalmed

Registered Apprentice No.

working under my personal supervision.

Signed Glenn E Kent

Licensed Embalmer No. 1769

P. O. Address Green City, Mo

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4626

Registration District No. 849

Primary Registration District No. 6123

Registrar's No.

1. PLACE OF DEATH:

(a) County... Sullivan
(b) City or town... Buchanan, Mo.
(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.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Carolyn Sue Mason

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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 Months Days If less than one day
3 4

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)..... (b)..... (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. A.?..... years.

RESIDENT CERTIFICATION

20. DATE OF DEATH: Month Jan day 18 year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....; that last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to Influenza

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) 33W

Major findings: Of operations..... Of autopsy.....

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 H. E. Schurr (M. D. or other).....

Address Blue City, Mo. Date signed 4-12-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

