

APR 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9482  
Registrar's No. 891

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson Co.  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Kansas City Tuberculosis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 months  
(Specify whether years, months or days)  
In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2316 Vine St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Pearl Stanford Mason

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color Blk. 6. (a) Single, widowed, married, divorced Wid?

6. (b) Name of husband or wife W. M. Mason 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Oct. 1, 1874  
(Month) (Day) (Year)

8. AGE: Years 46 Months 105 Days 1 If less than one day — hr. — min.

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

10. Usual occupation Housewife

11. Industry or business —

12. Name Jordan Stanford

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

14. Maiden name Lyne Hayden

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

16. (a) Informant Kansas City T. B. Hospital  
(b) Address Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Dover Mo.  
18. (a) Signature of funeral director W. M. Mason  
(b) Address W. M. Mason

19. (a) 3/3/41 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2 year 1941 hour 3 minute 35 P.M.

21. I hereby certify that I attended the deceased from July 27, 1940 to March 2, 1941 that I last saw her alive on March 2, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis Duration —

Due to 17 1/2

Due to 17 1/2

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy Palat. pulv. T. B. F. Broad uterus bilat. tuberculous abscesses.

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? 3/1/41 (Specify type of place) (e) Means of injury 0

23. Signature W. M. Mason (M. D. or other) Phys.  
Address K. C. T. B. Hospital Date signed 3/3/41

**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 *C W West*

Licensed Embalmer No. 2710

P. O. Address.....

**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, fact should be so stated above.**