

2-40
-39
K23159

OCT 18 1941
791

STANDARD CERTIFICATE OF DEATH

State File No. 30136
Registrar's No. 7475

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 0 years, months or days)

3. (a) PRINT FULL NAME Ruth Ann Mason

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

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

6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased June 22 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 2 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name E. B. Puryear

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

14. Maiden name Alice M. Grant

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

16. (a) Informant Mr. James Mason

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof 9/16/41
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) 9-16-41 (b) J. B. Decker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town Springfield N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. 807 S. Delaware
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16
year 1941 hour 6 minute 40 A.M.

21. I, hereby certify that I attended the deceased from September 14, 1941, to September 16, 1941 that I last saw her alive on September 16, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Benign
Due to.....
Due to.....

Other conditions (include pregnancy within 3 months of death) 56

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

Duration
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) by Means of injury.....

23. Signature J. B. Decker (M.D. or other)
Address 4952 Maryland Date signed 9/16/41

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

MOTHER FATHER

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.....

.....
Licensed Embalmer No.

P. O. Address.....

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.