

S. No. 2
1-5-42
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11073**
Registrar's No. **102**

Registration District No. **274**

Primary Registration District No. **3052**

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

1. PLACE OF DEATH:

(a) County **Pettis**

(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
117 E Morgan
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **1** (Specify whether)

In this community **✓**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pettis**

(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL.")

(d) Street No. **117 E. Morgan**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **0**

3. (a) PRINT FULL NAME **MIMNA A. MASON**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **F** 5. Color or race **N** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **0** 6. (c) Age of husband or wife if alive **0** years

7. Birth date of deceased **9 20 1884**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	6	2	hr. min.

9. Birthplace **Houstonia** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **Housewife**

11. Industry or business **Self**

12. Name **James Mason**

13. Birthplace **Houstonia Ky** (City, town, or county) (State or foreign country)

14. Maiden name **Mary E Clark**

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

16. (a) Informant **W A Mason**

(b) Address **Melunckel Wis**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-26-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Glennwood Cemetery**

18. (a) Signature of funeral director **J. O. Flynn**

(b) Address **117 E Jefferson St**

19. (a) **3-26-43** (Date received local registrar) **Anna Berger** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **22** year **1943** hour **8** minute **P** M.

21. I hereby certify that I attended the deceased from **Jan 1 - 43** to **Mar 22 1943**

that I last saw **her** alive on **Mar 22 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia**

Duration **3 wks**

Due to

Due to

Other conditions **Bronchiectasis** (Include pregnancy within 3 months of death) **Hypox**

PHYSICIAN

Major findings: Of operations **107**

Of autopsy

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 B Weathers** (M. D. or other) Address **118 1/2 W Main, Sedalia** Date signed **3/26/43**

1022

(Licensed Embalmer's Statement on Reverse Side)

mo

RECEIVED

District Health Officer No. 8,

District File Number -----

Date Filed 4-8-43

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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

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.