

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24844**  
Registrar's No. **47**

Primary Registration District No. **5410**

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

34  
00

FILED JUL 21 1943  
Registration District No. **101**

1. PLACE OF DEATH:

(a) County **Douglas**

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

(c) Name of hospital or institution: **1 Richard Dupps**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 hrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Douglas**

(c) City or town **Iron Bridges**  
(If outside city or town limits, write "RURAL")

(d) Street No. **R7D**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Wm Masterson**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **10**  
year **1943** hour **5** minute **00** **9** M.

21. I hereby certify that I attended the deceased from **7-27-1942** to **4-26-1943**  
that I last saw him alive on **9-11-1942**  
and that death occurred on the date and hour stated above.

4. Sex **m**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **2 divorced W**

6. (b) Name of husband or wife **Lessie Masterson**

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

7. Birth date of deceased **2-22-1864**  
(Month) (Day) (Year)

Immediate cause of death **Chronic Cardiac Valvular Disease (mitral insufficiency)**

Duration **92 hr**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years **79** Months **21** Days **28** If less than one day hr. min.

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

10. Usual occupation **Farmer**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name **James Masterson**

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

14. Maiden name **May Fitzpatrick**

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

16. (a) Informant **Blanche Holt**

(b) Address \_\_\_\_\_

17. (a) **B** (Burial, cremation, or removal) (b) Date thereof **5/12-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Light Glor**

18. (a) Signature of funeral director **Robertus**

(b) Address **West Plains Mo**

19. (a) **6-1-43** (Date received local registrar) (b) **Thelma Sitwats** (Registrar's signature)

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) Means of injury \_\_\_\_\_

23. Signature **E. C. Bohrer** (M. D. or other) **C. M.**

Address **West Plains, Mo** Date signed **6-1-43**

1096

Bohrer

RECEIVED

District Health Officer No. 6,

District File Number 743-897

Date Filed JUL 20 1943

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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Raymond D Roberts*

Licensed Embalmer No. 3435

P. O. Address West Plains, 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, fact should be so stated above.