

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

(b) City or town RUERAL B910

(c) Name of hospital or institution:  
2 1/2 miles East of Jackson  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 6 1/2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 2 1/2 miles East of Jackson  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SUSAN-KATHERINE MASON

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29 year 1943 hour \_\_\_\_\_ minute 6 A. M.

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

6. (b) Name of husband or wife John William Mason 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 4 1853  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-3-43 to 12-29-43 that I last saw her alive on 12-21-43 and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 4 Days 25 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

Immediate cause of death  
Pulmonary edema  
uremia  
Due to Chronic myocarditis  
Chronic Bright's disease (glomerulonephritis)  
Other conditions arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 131F

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name James Collison

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

14. Maiden name Catherine Seaburg

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

16. (a) Informant Adde Mason  
(b) Address Jackson mo

17. (a) Burial (b) Date thereof 12-31-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russell Heights

18. (a) Signature of funeral director Wilson Stath's Seaburg  
(b) Address Jackson mo

19. (a) 1/30 (b) J. H. Kestner  
(Date received local registrar) (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) \_\_\_\_\_  
(e) Manner of injury \_\_\_\_\_

23: Signature Richard Ester M. D. or other \_\_\_\_\_  
Address Jackson Date signed 12-29-43

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

16000

RECEIVED

District Health Officer No. 4  
District File Number 144-3213  
Date Filed 1-8-44

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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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.