. S. No. 2
DM—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30934

FILED OCT 13 1944

Registration District No. 1948

Primary Registration District No. 5466

Registrar's No. 759

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural, S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Days 0 (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Rural, S. Campbell Twp. Spfd.
(If outside city or town limits, write "RURAL")

(d) Street No. ~~Springfield, Mo.~~ Route #6
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Florence Mae Mason

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F M

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Reuben J. Mason

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased May (Month) 13, (Day) 1913 (Year)

8. AGE: Years 31 Months 4 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace Thayer (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business -----

FATHER
12. Name Robert A. Williams
13. Birthplace Etuck. (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Emma Nydegger
15. Birthplace Thayer (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Reuben J. Mason
(b) Address Rt. 6, Springfield, MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22, (Month) (Day) 1944 (Year)
(c) Place: burial or cremation Evergreen Cemetery

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address 629 N. Walnut, Springfield, Mo.

19. (a) 9-20-44 (Date received local registrar) (b) Dr W. J. Hand Ex (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th.
year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept. 8th, 1944 to Sept 19th, 1944
that I last saw her alive on Sept 18th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Embolis

Due to Ovarian cyst coupled red with adhesion of the

Due to Sigmoid and Ileum

Other conditions 56a
(Include pregnancy within 3 months of death)

Major findings:
Of operations As above

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature William L. Wetzel (M.D. or other)
Address 2100 S. Holland Spfd., Mo. Date signed Sept 20 '44

984 (Licensed Embalmer's Statement on Reverse Side)

OCT 19 1944

OCT 17 1944

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. D. McCalker

Licensed Embalmer No. 2891

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.