

S. No. 2
M-5-43
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39200**
Registrar's No. **11183**

FILED JAN 5 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis Missouri

(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis Childrens
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1532 Inge Place
(If rural, give location)

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

3. (a) PRINT FULL NAME Gloria Jeanette Mason

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

4. Sex Female 5. Color or race Colored

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

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

7. Birth date of deceased 8 14 44
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2
year 1944 hour 9 minute 52 A M.

21. I hereby certify that I attended the deceased from 11-29-44, 19____, to 12-2-44, 19____;
that I last saw her alive on 12-2-44, 19____;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
	<u>3</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Congenital Syphilis

Due to _____

Due to 287

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

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

Major findings:
Of operations _____

Of autopsy _____

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

11. Industry or business _____

MOTHER FATHER {

12. Name Thomas Oscar Mason

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

14. Maiden name Alma Turner

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant B. Finerman

(b) Address 500 So. Kingshighway

17. (a) Burial (b) Date thereof DEC 29 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

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? _____

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger St

19. (a) DEC 29 1944 (b) J. B. Brudeck
(Date received local registrar's certificate) (Registrar's signature)

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

23. Signature R. J. Blittner (M. D. or other) _____

Address 500 So. Kingshighway Date signed _____

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.