

FILED FEB 14 1945

Registration District No. **176**

Primary Registration District No. **6656-4579** Registrar's No. **8**

1. PLACE OF DEATH

(a) County **Ask Grove Miss Lawrence Co**
(b) City or town **Country Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 **at her life** years, months or days)

3. (a) PRINT FULL NAME **Lawrence Van Mason**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **9**

6. (b) Name of husband or wife **etc** 6. (c) Age of husband or wife if alive **11** years (Month) (Day) (Year) **1894**

7. Birth date of deceased **Feb 11 1894**
(Month) (Day) (Year)

8. AGE: Years **50** Months **11** Days **27** If less than one day hr. min.

9. Birthplace **Lawson Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Joseph P. Mason**
13. Birthplace **North Carolina**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Jane Smith**
15. Birthplace **Lawson Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Vagina Smith**
(b) Address **Ask Grove Mo**

17. (a) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation **Rocky Mountain**

18. (a) Signature of funeral director **A. S. Wallace**
(b) Address **Billings Mo**

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lawrence**
(c) City or town **Falltown**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **15** year **1945** hour **3** minute **0** M.

21. I hereby certify that I attended the deceased from **Nov. 20** 19**44** to **Jan 15** 19**45** that I last saw him alive on **Jan 10** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer originating in right kidney and spreading generally**
Due to **SA**
Due to

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

Major findings: Of operations: Of autopsy:

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 **S. M. Clark M.D.** (M. D. or other)
Address **Falltown Mo** Date signed **1-17-45**

Duration **3 months**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

11-2

RECEIVED

District Health Officer No. 6;

District File Number 245-207

Date Filed FEB 12 1945

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 Employ
Marsh, Registered Apprentice No. 2175
working under my personal supervision.

Signed

A. Wallace
Licensed Embalmer No. 2175

P. O. Address A. Wallace

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.

o. 2B
-5-43
X36930

Registration District No. 176 Primary Registration District No. 5656 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Maestata
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Lawrence W. Mason
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 11 1906
(Month) (Day) (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business Farmer

12. Name Joseph P. Mason

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

14. Maiden name Mary J. Smith

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

16. (a) Informant Virginia Smith

(b) Address Asht Grove, Mo.

17. (a) Burial (b) Date thereof 1-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Prairie

18. (a) Signature of funeral director G. S. Wallace

(b) Address Bellvue, Mo.

19. (a) 1-26-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Halltown
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb Day 15 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 S. M. Clark M.D. (M. D. or other) _____
Address Halltown, Mo. Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

Registration District No. 176

Primary Registration District No. 4299

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Haltom
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lawrence Mason

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

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

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

7. Birth date of deceased Feb (Month) 11 (Day) 1940 (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Anna Whindy (Registrar's signature)

(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 11 Year 1940 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed 1-18-40

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

SUPPLEMENTAL