

Registration District No. 227

Primary Registration District No. 4339

State File No.

Registrar's No. 11

1. PLACE OF DEATH:

(a) County MONROE
(b) City or town PARIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 401 W. MONROE ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 MONTH
(Specify whether
In this community WIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE
(c) City or town PARIS
(If outside city or town limits, write "RURAL")
(d) Street No. 311 E MARION ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME MATILDA JANE MASON

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife NATHAN FLETCHER MASON 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased DEC. 24, 1855
(Month) (Day) (Year)

8. AGE: Years: 89 Months: 2 Days: 7 If less than one day hr. min.

9. Birthplace MONROE CO., MO.
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

12. Name JAS. L. MCGEE

13. Birthplace NOT KNOWN
(City, town, or county) (State or foreign country)

14. Maiden name SUSAN JANE BRYAN

15. Birthplace NOT KNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant Elvise P. Mason
(b) Address PARIS, MO

17. (a) BURIAL (b) Date thereof MAR 4, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT GROVE

18. (a) Signature of funeral director Speed or Slakey
(b) Address Paris, Missouri

19. (a) Mar. 2, 1945 (b) Mayra Nelson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 1
year 1945 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Jan 23
1940 to Mar 1 1945
that I last saw her alive on Mar 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Pelvic Bone
Fall on Home!

Due to.....
Due to.....

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

Major findings:
Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?

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

23. Signature Geo W. Ruppel (M. D. or D. O.)
Address PARIS, MO Date signed 3/2/45

RECEIVED

District Health Officer No. 10

District File Number 4-45-683

Date Filed APR 13 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
..... Registered Apprentice No.
working under my personal supervision.

Signed

Dejon L. Kelsey

Licensed Embalmer No. 4225

P. O. Address Paris, Missouri.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

Registration District No. 227

Primary Registration District No. 4329

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Paris
(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 Matilda J. Mason

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

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

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

7. Birth date of deceased Dec 24
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days _____ Unless than one day _____ min.

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

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 18 Year 1945 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
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) no

(b) Date of occurrence Mar 2 - 1945

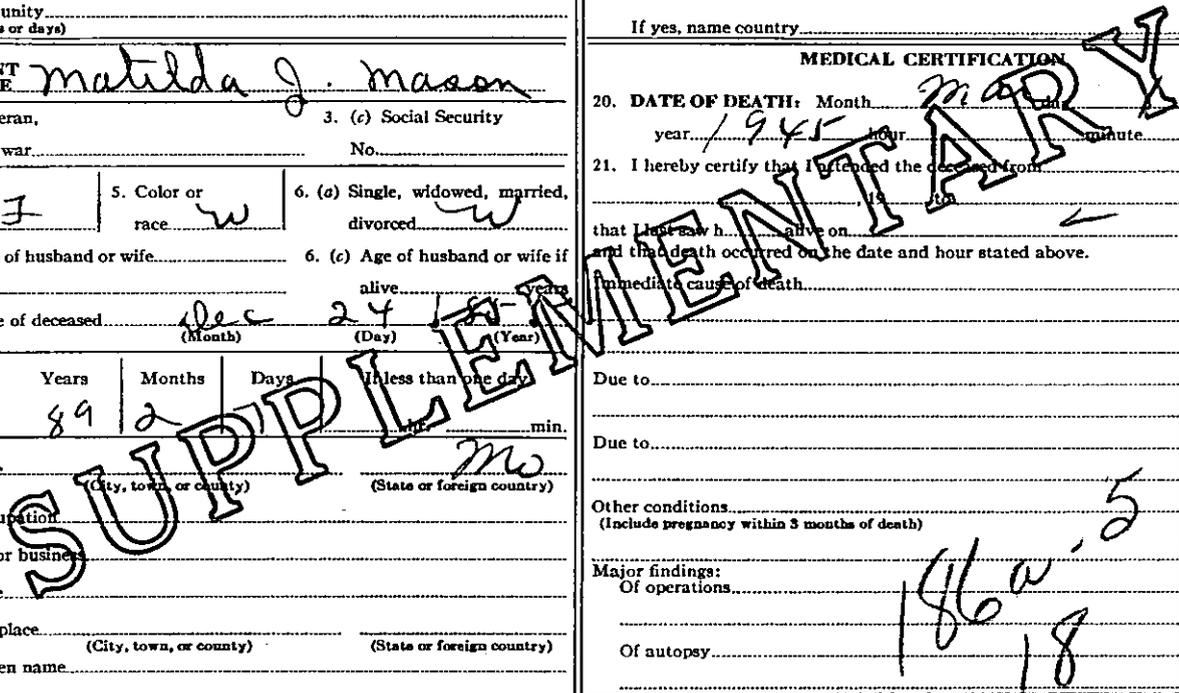
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____



WHITE PEARL CASE CONTAINER - DISINFECTED

14039