

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
FILED SEP 12 1945 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 322

Primary Registration District No. 447-23071

Registrar's No. 23

1. PLACE OF DEATH:  
 (a) County: Saline  
 (b) City or town: Slater  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: none  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution: no  
all his life (Specify whether  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: Mo. (b) County: Saline 97  
 (c) City or town: Slater 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.: ..... (If rural, give location) 1  
 (e) Citizen of foreign country? no (Yes or No) 0  
 If yes, name country: .....

3. (a) PRINT-FULL NAME: George Winston Mason

3. (b) If veteran, name war: no 3. (c) Social Security No.: none

4. Sex: male 5. Color or race: negro 6. (a) Single, widowed, married, divorced: widowed

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

7. Birth date of deceased: September 15 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>11</u>	<u>0</u>	hr. .... min.

9. Birthplace: Saline Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation: farmer

11. Industry or business: .....

12. Name: John J. Mason Va. /

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

14. Maiden name: Elizabeth Ann James Va. /

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

16. (a) Informant: Mary E. Carter  
(b) Address: Slater, Mo.

17. (a) burial (b) Date thereof: 8-19-'45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Slater, Mo.

18. (a) Signature of funeral director: Hill Brothers,  
(b) Address: Slater, Mo.

19. (a) Sept 6-45 (b) Mrs. John Giger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 15  
year: 1945 hour: 11.30 minute: ..... P. M.

21. I hereby certify that I attended the deceased from Aug. 2  
1945, to Aug. 15 1945.  
that I last saw him alive on Aug. 12 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis  
streptococcal

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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. Signatur: C. W. Redwell (M. D. or other)  
Address: Slater, Mo. Date signed: 8-18

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

MOTHER FATHER

1211

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-10-45

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. 1292

P. O. Address Slater 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 5291Registration District No. 322Primary Registration District No. 3071Registrar's No. 23

## 1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(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

George W. Mason

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased Sept 15  
(Month) (Day) (Year)8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, hr. \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1995 (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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions chronic hepatitis  
(Include pregnancy within 3 months of death)Major findings: CHRONIC HEPATITIS  
Of operations \_\_\_\_\_  
Of autopsy 1315 REQUESTED

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 W. A. [unclear] (M. D. or other) \_\_\_\_\_  
Address Slater Mo. Date signed 9-13-91

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

MOTHER FATHER

SUPPLEMENTARY

5-286-20

1053

1053

1053