

S. No. 2  
M-5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED** OCT 29 1945 **STANDARD CERTIFICATE OF DEATH**

32799

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4288

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Wheatley Provident Hosp.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10-12-45-10-14-45  
(Specify whether years, months or days)  
 In this community 20 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2200 Michigan  
(If rural, give location)  
 (e) Citizen of foreign country? No  
(Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Lula Mason  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Oct. day 14  
 year 1945 hour 7:45 minute P.M.

4. Sex 3 Fe 5. Color or race Col  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Wm. H. Mason  
 6. (c) Age of husband or wife if alive 62 years  
 7. Birth date of deceased March 4 1884  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-4- 1948 to 10-14- 1945  
 that I last saw her alive on 10-14- 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Type Heart Disease 2 yrs.  
 Duration \_\_\_\_\_

**8. AGE:** Years Months Days If less than one day  
61 7 10 hr. \_\_\_\_\_ min.

Due to Generalized Arterio Sclerosis

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

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

10. Usual occupation Housewife

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

11. Industry or business \_\_\_\_\_

Major findings: Exposure + Cold

12. Name Jesse Crowwhite

Of operations: 9/3/45

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

Of autopsy \_\_\_\_\_

14. Maiden name Elnora Smith  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Wm. H. Mason

(b) Address 2200 Michigan

17. (a) removal (b) Date thereof 10/19/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, Missouri

18. (a) Signature of funeral director Harkins Bros

(b) Address 1729 Lydia

19. (a) 10-18-45 (b) Gertrude Holman  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO

(b) Date of occurrence NO

(c) Where did injury occur? NO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
NO

While at work? NO (Specify type of place) (e) Means of injury 0

Signature J.S. Wells (M. D. or other)  
 Address 1227 E-15th R.C.M.O. Date signed 10-16-45

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

**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 *J. J. Manlove*  
Licensed Embalmer No. *3994*  
P. O. Address *2503 Highland*

**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.**