

**FILED** APR 17 1946

Registration District No. 178

Primary Registration District No. 5439

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Rural Canaan Twp  
(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 Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 37  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rosebud Route 1 0  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SIMON SYLVESTER MASON

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

4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Single 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased November 29 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 2 13 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Rosebud R.I. Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

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

12. Name Scott Mason

13. Birthplace Rosebud Missouri 0  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Henemann

15. Birthplace Sea Missouri 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Flora Mason  
(b) Address Rosebud, Mo. R.I.

17. (a) Burial (b) Date thereof Feb. 16 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Owensville City Cemetery

18. (a) Signature of funeral director Richard H. W. Winter  
(b) Address Owensville, Mo.

19. (a) 3-9-46 (b) Northy Beckman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3-12-46 1946 to 2-12-46 1946  
that I last saw him alive on 2-12-46 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Paraplegia 2 yrs  
Multiple Sclerosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy, within 3 months of death) \_\_\_\_\_  
Major findings: Of operations No operation  
Of autopsy No 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? \_\_\_\_\_

Specify type of place \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature H. L. Matthews M. D. or other? \_\_\_\_\_  
Address Brayport, Mo. Date signed 3/24/46

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-16-48

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 Me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Welford N. N. N...

Licensed Embalmer No. 3838

P. O. Address Owensville

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 118

Primary Registration District No. 5439

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Gasconade  
 (b) City or town Rural  
(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

Lincoln S. 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 S

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

7. Birth date of deceased Nov 29  
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days \_\_\_\_\_  
(Unless than one day)  
 hr. \_\_\_\_\_ 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 \_\_\_\_\_  
(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 April 2  
 year 1946 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 Multiple Cerebro

Due to Spinal Sclerosis

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) (c) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER, FATHER

11700

12797