

-2-43  
-17-39  
X35697

**FILED JUN 10 1946**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **597**

1. PLACE OF DEATH:  
**Buchanan**  
 (a) County **Buchanan**  
 (b) City or town **St. Joseph**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**125 Michigan Ave**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community **70 years**  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Buchanan** **11**  
 (c) City or town **St. Joseph** **1**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **125 Michigan Ave.** **7**  
 (If rural, give location) **0**  
 (e) Citizen of foreign country? **No.** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Sarah Elsie Mason**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow 2**  
 6. (b) Name of husband or wife **Alex Mason** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Feb. 27, 1872**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>74</b>	<b>2</b>	<b>20</b>	hr. min.

9. Birthplace **Nodaway County Missouri**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Own home**

12. Name **William Smallwood**

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

14. Maiden name **Nancy Stoneham**  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. Roy Montgomery**

(b) Address **125 Michigan Ave. St. Joseph, Mo**

17. (a) **Burial** (b) Date thereof **May 20, 1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Clark Montgomery**

(b) Address **6025 King Hill Ave.**

19. (a) **May 24, 1946** (b) **[Signature]**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **May** day **17**  
 year **1946** hour **5:00** minute **P** M.

21. I hereby certify that I attended the deceased from **Feb 28**, 19**46** to **May 17**, 19**46**  
 that I last saw h. or alive on **May 13**, 19**46**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chromonia**  
 Duration **6 days**

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

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

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

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION 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)  
 Means of injury \_\_\_\_\_

23. Signature **[Signature]** (M. D. or other)  
 Address **[Signature]** Date signed **5-21-46**

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

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**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 *E. A. Clark*

Licensed Embalmer No. **4258**

P. O. Address **St. Joseph, 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.**

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St Joseph  
(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 Sarah E. 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 Wed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Feb 27 (Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 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 May Day 17 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I had seen \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Bronchial Pneumonia  
Due to \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 107

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? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 6-17-46

14699 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

15804