

S. No. 2  
DM-5-43  
v. 5-17-39  
I X3657

**FILED JUN 26 1946**  
318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri Pacific Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert F. Mason

3. (b) If veteran, name was World War # 1

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eleanor Mason

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased September 10 1895  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>9</u>	<u>2</u>	hr. _____ min.

9. Birthplace Streator Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Assistant Engineer

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

12. Name Charles C. Mason

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

14. Maiden name Anna Frazier

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

16. (a) Informant A.P. Wagner

(b) Address 105 W. Cedar Ave.

17. (a) Burial (b) Date thereof 6-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marceline, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 12 1946 (Date registered) J. F. Bredsch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lynn

(c) City or town Marceline  
(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 June day 12  
year 1946 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 1st, 1946 to June 12, 1946  
that I last saw him alive on June 11, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Malignant hypertension

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

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

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 Moel C. Mullen (M. D. or other) M.D.  
Address Missouri Pacific Hospital Date signed 6-12-46

58  
2  
NR  
1

Duration  
6 weeks

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

JUL 2 1946

JUL 10 1946

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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

*John A. Czonaski*  
.....  
Licensed Embalmer No. *3398*  
.....  
P. O. Address.....

**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.**