. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26727

Registration District No. ____ Primary Registration District No. 5375 Registrar's No. 65

1. PLACE OF DEATH:
(a) County: De Kalb Co
(b) City or town: Rural Dallas
(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 ____ In this community: 3 months. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Gentry 38
(c) City or town: Albany 1
(If outside city or town limits, write "RURAL")
(d) Street No. ____ 0
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) /
If yes, name country ____

3. (a) PRINT FULL NAME: Permelia Ann Mason
3. (b) If veteran, name war ____
3. (c) Social Security No. ✓
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: O A Mason
6. (c) Age of husband or wife if alive ____ years: black
7. Birth date of deceased: Aug (Month) 30 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
75	11	1	____ hr. ____ min.

9. Birthplace: Gentry Co (City, town, or county) Mo: U (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____
MOTHER FATHER
12. Name: Hugh B Teel
13. Birthplace: not known (City, town, or county) (State or foreign country)
14. Maiden name: Permelia Ann Crowder
15. Birthplace: not known (City, town, or county) (State or foreign country)
16. (a) Informant: Floyd Mason
(b) Address: Pattonsburg Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-3-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Fairview Cemetery
18. (a) Signature of funeral director: G Brown
(b) Address: Pattonsburg Mo
19. (a) 8-10-46 (Date received local registrar) (b) Lora Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 1 day 1 year 1946 hour 1025 minute A M.
21. I hereby certify that I attended the deceased from July 13, 1946, to Aug 1, 1946 that I last saw h. alive on Aug 1, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of right temple area; — Duration: 5 yr.
Due to: Bed of bleeding calcum
Due to: ____
Other conditions (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? ____ (Specify type of place)
While at work? ____ (e) Means of injury: ____

23. Signature: H. Lord Taylor (M. D. or other) M.D.
Address: Maryville, Mo Date signed: 8-2-46

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 G S Gromer

Licensed Embalmer No. 2857

P. O. Address Pattonsburg 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.

No. 2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 99 Primary Registration District No. 5875 Registrar's No. 65

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

1. PLACE OF DEATH:

(a) County De Kalb

(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)

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

3. (a) PRINT FULL NAME Permelia A. 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 30 (Day) 18 (Year)

8. AGE: Years 75 Months 11 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of right Temporal area of Cranium (Primary site)

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 Harold Fowler (M. D. or other) M.D.

Address Date signed

SUPPLEMENTARY

25573

26727