S. No. 2
M—5-43
v. 5-17-39
o I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1946

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33332

Registrar's No. 9065

1. PLACE OF DEATH:

(a) County —

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

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

(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-0-0

(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL") 17

(d) Street No. 1024 Oakview Pl (If rural, give location) 4 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Edgar Mason

3. (b) If veteran, name war no

3. (c) Social Security No. 488-05-0545

4. Sex Male O

5. Color or race white

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

6. (b) Name of husband or wife Robbie D. Mason

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Dec. (Month) 21 (Day) 1868 (Year)

8. AGE: Years 77 Months 10 Days 1 If less than one day hr. min.

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

10. Usual occupation Salesman

11. Industry or business

FATHER 12. Name Jamrs Mason

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

MOTHER 14. Maiden name Sarah McCullough

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

16. (a) Informant Mrs. Robbie Mason

(b) Address 1024 Oakview Pl.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 24 46 (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo.

18. (a) Signature of funeral director Allgandle & Sons

(b) Address 6175 Delmar Blvd.

19. (a) OCT 23 1946 (Date received by registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22 year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Oct. 3, 1946 to Oct. 22, 1946; that I last saw him alive on October 22, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage — Duration

Due to Ruptured esophageal varix

Due to Laënnec's cirrhosis

Bleeding 1 day

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Same as above

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 O

23. Signature F R Bradley (M. D. or other)

Address Barnes Hospital Date signed 10/22/46

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas R Lemrick

Licensed Embalmer No. 3793

P. O. Address 6175 Delmar

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.