No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19143

FILED JUN 5 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5187

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

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: Lennox Hotel 3
(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 New York (b) County New York 999

(c) City or town New York 20
(If outside city or town limits, write "RURAL")

(d) Street No. NR 162 W. 54th St. 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Harry C. Mason

3. (b) If veteran, name war No

3. (c) Social Security No. 078-10-8409

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased August (Month) 16 (Day) 1879 (Year)

8. AGE: Years 67 Months 9 Days 6 If less than one day hr. min.

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

10. Usual occupation Salesman

11. Industry or business

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

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

16. (a) Informant Mabel Mason
(b) Address 162 W. 54th St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-23-47 (Month) (Day) (Year)
(c) Place: burial or cremation New York, N.Y.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAY 24 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~March~~ May day 22
year 1947 hour 11 minute 35 P 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 Coronary Occlusion

Due to Coronary Sclerosis

Due to

Other conditions 94a
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 2

23. Signature Dr. Alfred J. Perry (M. D. or other)

Address Dep. Coroner Date signed 5/24/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 B W Wilkerson

Licensed Embalmer No. 3575

P. O. Address St Louis 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.

S. No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Lenox Hotel
(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 New York (b) County N. Y.

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No. 162 W 54th St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Harry C Mason

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 16 (Day) 1879 (Year)

8. AGE: Years 67 Months 9 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) (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) May 24-47 (Date received local registrar) (b) MAY 31 1947 (Registrar's signature) J. F. Bennett

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1947 hour 11 minute 35 P. 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.

	Duration
Immediate cause of death	
Due to	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-19143