

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

FILED AUG 13 1947

Registration District No. **311**

Primary Registration District No. **6053**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **St Clair**  
 (b) City or town **Rural Monegaw**  
 (c) Name of hospital or institution: **12 mi south Appleton City**  
 (d) Length of stay: In hospital or institution **home**  
 In this community **7 months**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St Clair**  
 (c) City or town **Appleton City**  
 (d) Street No. **Rural**  
 (e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Wisey Neal Masten**

3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex **male** 5. Color or race **White** 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 **Jan 20 1947**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**6 17** hr. min.

9. Birthplace **St Clair MO**  
 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Truman H Masten**  
 13. Birthplace **MO**  
 14. Maiden name **Irma Lorraine Hagler**  
 15. Birthplace **MO**

16. (a) Informant **Truman H Masten**  
 (b) Address **Appleton City MO**

17. (a) **Burial** (b) Date thereof **Aug 8 1947**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Zion Church**

18. (a) Signature of funeral director **Frank**  
 (b) Address **Appleton City MO**

19. (a) **Aug 9 1947** (b) **Chas Atkey**  
 (Date registered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **7**  
 year **1947** hour **7:00** minute **P** M.

21. I hereby certify that I attended the deceased from **seen**  
**only after death**, 19 **47**;  
 that I last saw him alive on **20** **Aug**, 19 **47**;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pertussis**

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **9**  
 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? **0**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **WJ** (M. D. or other) **MD**  
 Address **Appleton City MO** Date signed **Aug 47**

RECEIVED  
District Health Officer No. 7,  
District file number 7-47-928  
Date Filed 8-12-47

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 *Act*  
Aug 7th 1947, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *Frank Lee*

Licensed Embalmer No. 10 99

P. O. Address *Appleton City 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. 311

Primary Registration District No. 6053

1. PLACE OF DEATH:

(a) County St Clair  
(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

3. (a) PRINT FULL NAME Wiley N. Master

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Jan 20 (Month) (Day) (Year)

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

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

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

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

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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) Mrs. Alice Abrey (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Clair  
(c) City or town Appleton City Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

5-25194