

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County **JACKSON**
 (b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **16 DAYS**
(Specify whether years, months or days)
 In this community **35 YRS.**

3: (a) PRINT FULL NAME **GRANDY MASON**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **NONE**

4. Sex **MALE** 2
 5. Color or race **NEGRO**
 6. (a) Single, widowed, married, divorced **SINGLE**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **AUGUST 10, 1904**
(Month) (Day) (Year)

8. AGE: Years **44** Months **0** Days **25**
 If less than one day hr. _____ min. _____

9. Birthplace **MEMPHIS TENNESSEE**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business _____

12. Name **FRANK MASON**

13. Birthplace **TENNESSEE**
(City, town, or county) (State or foreign country)

14. Maiden name **IRENE**

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

16. (a) Informant **MAE JOHNSON (SISTER)**

(b) Address **1320 EUCLID**

17. (a) **Burial** (b) Date thereof **9-10-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Blue Ridge Lawn**

18. (a) Signature of funeral director **Thymus H. Greenstreet**

(b) Address **1819 E. 15th St. K C 12 Mo**

19. (a) **9-9-48** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1610 MICHIGAN**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **SEPTEMBER** day **5**, year **1948** hour **3:** minute **20 P.** M.
 21. I hereby certify that I attended the deceased from **JULY 20, 1948** to **SEPTEMBER 5, 1948**, that I last saw him alive on **SEPTEMBER 5, 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **THROMBOSIS OF RIGHT CEREBRAL ARTERY**
 Due to _____
 Due to _____
 Other conditions **8/3/48**
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy **SSAME 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? _____

While at work _____ (Specify type of place)
 (c) Means of injury **0**
 23. Signature **Frank Mason** (M. D. or other)
 Address **GENERAL HOSPITAL NO. 2** Date signed **9/7/48**

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 W. G. Flynn

Licensed Embalmer No. 4383

P. O. Address. 1819 E. 15 K @ 1 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.