

No. 300
10-47
5-17-39
PI 3908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **147**

Primary Registration District No. **1002**

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:
3120 Summit Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **28 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mrs. Dica A. Mason**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Henry Mason** 6. (c) Age of husband or wife if alive **5th. 1850** years (Month) (Day) (Year)

7. Birth date of deceased **October 5th. 1850**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	98	0	26	hr. min.

9. Birthplace **Nashville Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Kimber Taylor**

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

14. Maiden name **Caroline McElhannon**

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

16. (a) Informant **Mrs. T. L. Cockrell**

(b) Address **803 W. 54th. Street**

17. (a) **Burial** (b) Date thereof **11-3-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Missouri**

19. (a) **11-3-48** (b) **Seraldine Holman**
(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. **3120 Summit Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **1st.**
year **1948** hour **7** minute **05 P.** M.

21. I hereby certify that I attended the deceased from **Somerset, Mo.** 19 **11** to **Nov 1** 19 **48**
that I last saw him alive on **Nov 1** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial**
arterio Sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **ASD**
Of autopsy _____

Duration **7yrs**
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? _____

John O. Skinner (Specify type of place) **D**
While at work? _____ (e) Means of injury _____

23. Signature **John O. Skinner** (M. D. or other) **D**
Address **140 S. T. C. Co.** Date signed **11/2-48**

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

MOTHER FATHER

2108
P
M

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 Amu C. Redburn

Licensed Embalmer No. 3495

P. O. Address J. C. 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.