

FILED AUG 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27804

State File No. \_\_\_\_\_

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 301

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Farmington RURAL St. Francois</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>		d. STREET ADDRESS (If rural, give location) <u>3510 Isolda</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CHARLES (CARL)</u>	b. (Middle) <u>FRANK</u>	c. (Last) <u>MAST</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 22, 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Nov. 22, 1886</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR (Months) <u>8</u>	IF UNDER 1 YEAR (Days) <u>0</u>	IF UNDER 1 YEAR (Hours) <u>0</u>	IF UNDER 1 YEAR (Min.) <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown - has worked</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at Wagner Electric</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Fred Mast</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Summers</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Kramer</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records State Hospital No. 4, Farmington, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>45 min</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis - Generalized</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis with cerebral arteriosclerosis 9 yrs.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 29, 1940, to July 22, 1949, that I last saw the deceased alive on July 22, 1949, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Samuel L. Horton</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	23c. DATE SIGNED <u>7-28-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 28, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State Hospital No. 4 Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Farmington, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Aug. 12, 1949</u>	REGISTRAR'S SIGNATURE <u>Esther Rudolph</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Cozean Funeral Home, Farmington, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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SEP 2 1949

RECEIVED 8-22-49

Health Officer No. 4

File Number 849-11

Date filed

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

Student Embalmer No.

working under my personal supervision.

Signed *C. H. Cozlen*

Signed Student Embalmer

Licensed Embalmer No. 4084

P. O. Address *Farmington*

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.