No. 300
10.48

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

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25047

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6766

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
c. LENGTH OF STAY (in this place) 23
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 913 Carroll

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis 2239
d. STREET ADDRESS (If rural, give location) 913 Carroll

3. NAME OF DECEASED (Type or Print)
a. (First) William b. (Middle) E c. (Last) Mason

4. DATE OF DEATH (Month) 8 (Day) 6 (Year) 50

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH —

9. AGE (In years last birthday) About 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Woodrow Mason

13b. MOTHER'S MAIDEN NAME Jane Ketcherside

14. NAME OF HUSBAND OR WIFE Bertha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME Bertha Mason **ADDRESS** 913 Carroll

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Chronic Myocarditis

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 4221

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Patrick E. Taylor (Degree or title) Cor

23b. ADDRESS 1500 Clark

23c. DATE SIGNED 8. 9. 50.

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 8-8-50

24c. NAME OF CEMETERY OR CREMATORY Flat River

24d. LOCATION (City, town, or county) Flat River (State) Mo

DATE REC'D BY LOCAL REG. AUG 9 1950

REGISTRAR'S SIGNATURE J B Sasaler

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

9929

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.

Student .....
Student Embalmer

Signed J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address St Louis 10 M

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.