

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **5178**

BIRTH NO. **FILED MAR 3 1954** REG. DIST. NO. **150** PRIMARY REG. DIST. NO. **5572** Registrar's No. **24**

<b>1. PLACE OF DEATH</b> a. COUNTY <p align="center"><b>Jackson</b></p>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission). a. STATE <p align="center"><b>Missouri</b></p>		b. COUNTY <p align="center"><b>Jackson</b></p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center"><b>Rural Prairie Township, Mo</b></p>		c. LENGTH OF STAY (in this place) <p align="center"><b>6da</b></p>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center"><b>Kansas City 3618</b></p>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center"><b>Jackson County Hospital</b></p>		d. STREET ADDRESS (If rural, give location) <p align="center"><b>4525 Chestnut 1</b></p>			
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>John</b>			b. (Middle) <b>F.</b>		c. (Last) <b>Mason</b>
<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <p align="center"><b>Feb. 16, 1954</b></p>		<b>5. SEX</b> <input checked="" type="checkbox"/> Male <b>6. COLOR OR RACE</b> <input checked="" type="checkbox"/> White			
<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <p align="center"><b>Married</b></p>		<b>8. DATE OF BIRTH</b> <p align="center"><b>4-29-1900</b></p>		<b>9. AGE</b> (In years last birthday) <b>53</b> <b>10. MONTHS</b> <b>9</b> <b>11. DAYS</b> <b>18</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p align="center"><b>Laborer</b></p>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <p align="center"><b>Hay mill</b></p>		<b>11. BIRTHPLACE</b> (State or foreign country) <p align="center"><b>Stet, Missouri</b></p>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <p align="center"><b>U.S.A.</b></p>		<b>13a. FATHER'S NAME</b> <p align="center"><b>Jacob Mason</b></p>		<b>13b. MOTHER'S MAIDEN NAME</b> <p align="center"><b>Mary Yater</b></p>	
<b>14. NAME OF HUSBAND OR WIFE</b> <p align="center"><b>Mary Mason</b></p>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> no <b>16. SOCIAL SECURITY NO.</b> <b>516-10-5759</b>			
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <p align="center"><b>Mrs Mary V. Mason</b></p>		<b>17. ADDRESS</b> <p align="center"><b>4525 Chestnut</b></p>			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c) <p><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i></p>		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Cholelithiasis</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <p align="center"><b>2 wks.</b></p>
		<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <p align="center">DUE TO (b) _____ DUE TO (c) <b>Hypertension &amp; Arteriosclerosis</b></p>			
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <p align="right"><b>332 X</b></p>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from</b> <b>1/6/1954</b> , 19 <b>54</b> , to <b>2/16/1954</b> , that I last saw the deceased alive on <b>2/15</b> , 19 <b>54</b> , and that death occurred at <b>6:10a m.</b> , from the causes and on the date stated above.					
<b>23a. SIGNATURE</b> <p align="center"><i>[Signature]</i></p>		<b>23b. ADDRESS</b> <p align="center"><b>Jackson County Hospital</b></p>		<b>23c. DATE SIGNED</b> <p align="center"><b>2/16/1954</b></p>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <p align="center"><b>Burial</b></p>		<b>24b. DATE</b> <p align="center"><b>2-18-54</b></p>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <p align="center"><b>Mc Bee Chapel Cem, Near Braymer Mo.</b></p>	
<b>24d. LOCATION</b> (City, town, or county) (State) <p align="center"><b>Mo.</b></p>		<b>DATE REC'D BY LOCAL REG.</b> <p align="center"><b>2/16/54</b></p>		<b>REGISTRAR'S SIGNATURE</b> <p align="center"><b>D.B. Langford</b></p>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <p align="center"><b>J.W. Wagner</b></p>		<b>ADDRESS</b> <p align="center"><b>KC Mo.</b></p>			

(Licensed Embalmer's Statement on Reverse Side)

No. 300  
10.48  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 Alvin R. Haunschild

Licensed Embalmer No. 4159

P. O. Address K.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.