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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36604

FILED DEC 6 1954

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1235</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>	c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>708 No. 4th St.</u>			No. STREET ADDRESS <u>708 No. 4th St.</u>		0117 0		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u> b. (Middle) <u>Kelso</u> c. (Last) <u>Mason</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25, 1954</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 30, 1875</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. River work</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Keytesville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James R. Mason</u>		13b. MOTHER'S MAIDEN NAME <u>Adra Kelso</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS <u>Frank C. Mason 41 S. Bethany, Kansas City, Kan.</u>			
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.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Ukn.</u>
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cardiac Asthma with decompensation</u>				<u>Ukn.</u>
			DUE TO (c) _____				
			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 <u>4-3-4-2</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-26, 1953</u> , to <u>11-25 1954</u> , that I last saw the deceased alive on <u>11-25, 1954</u> , and that death occurred at <u>9:00a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. F. Mundy M.D.</u>			23b. ADDRESS <u>2801 Sacramento St. Joseph, Mo.</u>			23c. DATE SIGNED <u>11/26/54</u>	
24a. FUNERAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 27, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Keytesville, Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Keytesville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Nov 29, 1954</u>		REGISTRAR'S SIGNATURE <u>Walter M. Allison</u>		485 25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark Funeral Home</u>		ADDRESS <u>St. Joseph, Mo.</u>	

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

DEC 6 1954

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.....  
Signature of Student Embalmer

Signed *Eme A Clark*

Licensed Embalmer No. *47*

P. O. Address *S. J. J. J.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.