

FILED MAY 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **18298**
Registrar's No. **4308**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1829 Lafayette Ave.		e. STREET ADDRESS (If rural, give location) 1829 Lafayette Ave. 22370	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JOSEPHINE	b. (Middle)	c. (Last) MASON	Month April	Day 29	Year 1956

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June, 10, 1869	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
----------------------	-------------------------------	-----------------------------------------------------------------------	----------------------------------------	-------------------------------------------	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA.
--------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------------	------------------------------------------

13a. FATHER'S NAME Isaac Menk	13b. MOTHER'S MAIDEN NAME Margaret ?	14. NAME OF HUSBAND OR WIFE John F. Mason
--------------------------------------	---------------------------------------------	--------------------------------------------------

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. None	17. INFORMANT'S SIGNATURE OR NAME Ethel Mason	ADDRESS 1829 Lafayette Ave.
----------------------------------------------------------------------------------------------------------	-------------------------------------	------------------------------------------------------	------------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inferioritis		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma left breast		
	DUE TO (c) Cardiovascular disease		
	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 <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)	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 **Jan**, 19**54**, to **April**, 19**56**, that I last saw the deceased alive on **April 29**, 19**56**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Theodore A. Schubert M.D.	23b. ADDRESS 2000 S 83rdway	23c. DATE SIGNED 5/1/56
-------------------------------------------------------------------	------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Operation	24b. DATE 5/2/56	24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
------------------------------------------------------------	-------------------------	--------------------------------------------------------------	--------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. MAY 2 1956	REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE CHULICK UND. CO.	ADDRESS 1722 S. Jefferson
--------------------------------------------	------------------------------------------	----------------------------------------------------------	----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 430

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.