

FILED FEB 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4870
State File No. _____
536
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Kansas City)		c. LENGTH OF STAY (in this place township) 30 years		c. CITY OR TOWN Kansas City		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 6512 Linden Road				e. STREET ADDRESS (If rural, give location) 6512 Linden Road					
3. NAME OF DECEASED (Type or Print) a. (First) ETHEL		b. (Middle)		c. (Last) MASON		4. DATE OF DEATH (Month) (Day) (Year) Feb. 3, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 5, 1900		9. AGE (In years last birthday) 57 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) Partner, Tom Mason Truck Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME Volney Primm		13b. MOTHER'S MAIDEN NAME Minnie Ehlers		14. NAME OF HUSBAND OR WIFE Thomas P. Mason					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-36-4891		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thomas P. Mason Kansas City, Mo.					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Influenza II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 444x	
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) 9					
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>1930</u> , 19 <u> </u> , to <u>February</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 31, 1957</u> and that death occurred at <u>2 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Delon A. Williams, M.D.				23b. ADDRESS 806 Pro Bldg		23c. DATE SIGNED 2/3/57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-6-57		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
DATE REC'D BY LOCAL REG. 2-4-57		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary Kansas City, Mo.					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Delon A. Williams

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 *Walter H. Erwin*

Licensed Embalmer No. *435*

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