

FILED APR 15 1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

7701

STATE FILE NUMBER

380

 Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

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, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #2.</u>		Length of stay in lb <u>45 yrs.</u>	d. STREET ADDRESS <u>1303 S. Noyes Blvd</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>V.</u> Last <u>Mason</u>			4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 15, 1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. B. & Q. R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Washington, Iowa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William V. Mason</u>			14. MOTHER'S MAIDEN NAME <u>Elvira S. Smith</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>488-14-3627</u>	17. INFORMANT Address <u>Richard W. Mason St. Joseph, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Recent hip fracture</u>			2 months	
		DUE TO (c)			<u>9036.44</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell over scales at Katz Drug Store at 6th & Edmond Streets</u>					
20c. TIME OF INJURY Hour <u>?</u> a. m. <u>?</u> p. m. <u>?</u>	<u>St. Joseph, Mo.</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Katz Drug Store</u>	20f. CITY, TOWN, OR LOCATION <u>131</u>	COUNTY <u>Buchanan</u>	STATE <u>Missouri.</u>		
21. I attended the deceased from <u>4/5/57</u> , to <u>4/5/57</u> , and last saw ^{her} <u>him</u> alive on <u>4/5/57</u> . Death occurred at <u>8:50</u> P. <u>m</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>G. E. Gossamer M.D.</u> (Degree or title)			22b. ADDRESS <u>State Hospital 7. City</u>		22c. DATE SIGNED <u>4/5/1957.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 8, 1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>			
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 9, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
balmed, or by, Student Embalmer No.
.....ing under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Albert R. Harrington

Licensed Embalmer No. 325

P. O. Address ..St. Joseph

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