

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012005

STATE FILE NUMBER

318

1003

2837

Registration District No.

Primary Registration District No.

Registrar's No.

300

-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no cause listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b #1. 5 wks.	d. STREET ADDRESS (If outside, give location) 2927 No. 13th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C Last MASON			4. DATE OF DEATH Month MARCH Day 19 Year 1958		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1902		9. AGE (In years last birthday) 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Mfg. Elec. Equip.		11. BIRTHPLACE (City and state or country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U S A			13a. FATHER'S NAME William O. Mason		
13b. MOTHER'S MAIDEN NAME Mary Anice Hubbard			14. NAME OF HUSBAND OR WIFE Alice L. Glover		
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. 425-18-2842		17. INFORMANT Claude Mason Address Sullivan, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - Terminal Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Squamous Cell Carcinoma (acromioclavicular joint) DUE TO (c) with rod metastases					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input 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.) 191-1		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION 3/10/58		
20g. COUNTY			20h. STATE		
21. I attended the deceased from 2-1-58 to 3/10/58 and last saw her/him alive on 3/10/58 Death occurred at 12:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Daron M Bernstein MD (Degree or title)			22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 3/10/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-12-58		23c. NAME OF CEMETERY OR CREMATORY Mounds Park Cemetery	
23d. LOCATION (City, town, or county) Lilbourn, Missouri		23e. STATE Missouri			
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc. 1936 St.Louis Av,			25. DATE RECD. BY LOCAL REG. MAR 11 '58		26. REGISTRAR'S SIGNATURE [Signature]

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 Delia J. Krispin

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.