Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007426
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2081

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CIT HOSP. #1. Length of stay in Ib	d. STREET ADDRESS (If outside, give location) 2320 Howard St. Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: CECIL	Middle: RONALD	Last: MASON	4. DATE OF DEATH Month Day Year: FEB. 26, 1959	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: April 29, 1907	9. AGE (In years last birthday): 51 — 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): Salesman	10b. KIND OF BUSINESS OR INDUSTRY: Farm & Home	11. BIRTHPLACE (City and state or country): Dent Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: Elmer Mason	13b. MOTHER'S MAIDEN NAME: Rowena Beckham	14. NAME OF HUSBAND OR WIFE: Corrine Mason		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: --	17. INFORMANT: Mrs. C. Mason	Address: 2320 Howard St.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumococcal Meningitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Otitis Media.

DUE TO (c) 391.2

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 ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2/25/59 1:45A.M, to 2/26/59 and last saw her/him alive on 2/26/59. Death occurred at 7:05 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Barry J. Stein (Degree or title) MD

22b. ADDRESS 1515 LAFAYETTE AVE

22c. DATE SIGNED 2/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify) removal

23b. DATE 3-2-59

23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery

23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)

24. FUNERAL DIRECTOR Robert D. Kinealy ADDRESS 2228 St. Louis Ave.

25. DATE RECD. BY LOCAL REG. FEB 27 '59

26. REGISTRAR'S SIGNATURE Hoard Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Gustav M. Disterle

Licensed Embalmer No. 4359

P. O. Address St. Louis 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.