

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011945
STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 322

Primary Registration District No. 3071

Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		c. CITY OR TOWN <u>Slater</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bridges Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Masterson</u>		4. DATE OF DEATH Month Day Year <u>March 25, 1959</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 checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		11. BIRTHPLACE (City and state or country) <u>Stanberry, Missouri</u>	
13a. FATHER'S NAME <u>Robert W. Masterson</u>		14. NAME OF HUSBAND OR WIFE <u>Maude Hunnecut</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>		17. INFORMANT <u>S. C. Masterson, Slater, 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>Left Ventricular failure.</u> DUE TO (b) <u>Hypertensive Cardio-Vascular disor.</u> DUE TO (c) <u>Hypostatic Pneumonia.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>	
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <u>7 1/2 A.M.</u>		22a. SIGNATURE (Degree or title) <u>S. N. Nolen</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/25/1959</u>	
24. FUNERAL DIRECTOR <u>Haines Funeral Home, Slater, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3/27/59</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. E. C. Metz</u>		27. DATE SIGNED <u>3-25-59</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Color, cancer, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

APR 9 1959

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 J. Harris*

Licensed Embalmer No. *4557*

P. O. Address *Walter J. Harris*

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.