URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-010182

FILED VS APR 12 1960 53

Registration District No. _____ Primary Registration District No. 3010 Registrar's No. 149

STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau — Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION S.E. Mo. Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cape Girardeau
c. CITY OR TOWN Jackson — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Route 3 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Oscar Middle: Last: Mason

4. DATE OF DEATH Month: April Day: 2 Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12/18/1887
9. AGE (last birthday): 72 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): Jackson, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: John Mason
13b. MOTHER'S MAIDEN NAME: Susan Cullison
14. NAME OF HUSBAND OR WIFE: Carrie Steimal 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: Carrie Steimal Mason — Address: Jackson, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	3 days
DUE TO (b)	Cerebral Arteriosclerosis	3 yrs.
DUE TO (c)		

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

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 April 7, 1952, to April 2, 1960 and last saw her/him alive on April 1, 1960
Death occurred at 11-15- p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. N. Jaeger M.D.
22b. ADDRESS: Jackson, Mo
22c. DATE SIGNED: Apr 4, 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: April 5, 1960
23c. NAME OF CEMETERY OR CREMATORY: Russell Heights
23d. LOCATION (City, town, or county): Jackson (State): Missouri

24. FUNERAL DIRECTOR: S.C. Cracraft — ADDRESS: Jackson, Mo.
25. DATE RECD. BY LOCAL REG.: 4-6-60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

APR 21 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Jackson

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