

# COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045588

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 434

**FILED DEC 19 1961**

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		c. CITY OR TOWN <b>Kirksville</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2314 Palmyra Road</b>		d. STREET ADDRESS (If outside, give location) <b>Sigma Gamma House</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>OLLIE</b> Last <b>MASON</b>			4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1961</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1881</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>15</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE MOTHER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Sigma Gama</b>	11. BIRTHPLACE (City and state or country) <b>Queen City Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Not Known</b>	13b. MOTHER'S MAIDEN NAME <b>Not Known</b>	14. NAME OF HUSBAND OR WIFE <b>Andrew Mason</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Ralph Davidson Hannibal Missouri</b>
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18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b>		
DUE TO (b)		
DUE TO (c) <b>Hypertensive Cerebral Vascular Disease</b>		<b>years</b>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b>11/12/61</b> to <b>11/20/61</b>	20f. CITY, TOWN, OR LOCATION <b>Hannibal Marion Mo.</b>	COUNTY <b></b> STATE <b></b>
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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.)	20f. CITY, TOWN, OR LOCATION <b>Hannibal Marion Mo.</b>	COUNTY <b></b> STATE <b></b>
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21. I attended the deceased from <b>8:00</b> on <b>11/12/61</b> to <b>11/20/61</b> and last saw her/him alive on <b>11/20/61</b>	
Death occurred at <b>8:00</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>J. H. Wadsworth M.D.</b>	22b. ADDRESS <b>1209 Broadway, Hannibal, Mo.</b>	22c. DATE SIGNED <b>12/8/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/9/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville Mo</b>
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24. FUNERAL DIRECTOR <b>W. Crawford Smith Hannibal Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 7, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Luche by Lillian M. Norman</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 John S. Strong

Licensed Embalmer No. 4540

P. O. Address Hannibal Miss

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.