LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12103

1. PLACE OF DEATH

County Jasper — Registration District No. 417 — File No.

Township — Primary Registration District No. 3021 — Registered No. 59

City Webb City, Jasper County Tuberculosis Hospital St. Ward)

2. FULL NAME Mark G. Hudson

(a) Residence. No. St., Ward. ~~Sarcoxie Mo~~
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 6 mos. ✓ ds. How long in U.S., if of foreign birth? ✓ yrs. ✓ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Divorced

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 1877

7. AGE: Years 47 — Months 3 — Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Diamond
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Erby Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Polina Mason
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee

14. INFORMANT Ed Hudson
(Address) Sarcoxie Mo

15. FILED 4-13 1925 R. M. Dormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4 1925

17. I HEREBY CERTIFY, That I attended deceased from November 5, 1924, to April 4, 1925, that I last saw him alive on April 4, 1925, and that death occurred, on the date stated above, at 8:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis, chronic, pulmonary

233

(duration) 4 yrs. 5 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? no
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical examination

(Signed) Varney Hazlewood M. D
April 4, 1925 (Address) Jasper County Tuberculosis Hospital Webb City Missouri

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Humphry Cemetry — DATE OF BURIAL: 4-5 1925

20. UNDERTAKER: R E Thayer — ADDRESS: Sarcoxie Mo

J H Bradley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... ..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT ....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,19.....
that I last saw h..... alive on.....,19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... , M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD