

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

Do not use this space.

11849

1. PLACE OF DEATH

County Jackson
Township Llanus
City Kansas City Mo (No. 022)

Registration District No. 399
Primary Registration District No. 1022

File No. _____
Registered No. 1045
St. _____ Ward) _____

2. FULL NAME

William Hudson

(a) Residence. No. 247 West 3d St. _____ Ward. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

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

Mar 1885

7. AGE

42

YEARS

MONTHS

DAYS

IF LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED

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

porter 34 10 R

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Arkansas

(STATE OR COUNTRY)

10. NAME OF FATHER

Wickers

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Arkansas

12. MAIDEN NAME OF MOTHER

Wickers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Arkansas

14.

INFORMANT (Address)

Mr Glover 1117 W. 3rd

15.

FILED

4/20 27 m m Broome Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

4-13 1927

17.

I HEREBY CERTIFY, That I attended deceased from 4-12, 1927, to 4-13, 1927 that I last saw him alive on 4-13, 1927, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Syphilis

CONTRIBUTORY (SECONDARY)

30 Hypostatic pneumonia
Lobar (duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH. NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Dr M. Smith M. D.

4/14 1927 (Address) 22nd & Mc Coy Old City Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Leeds mo

DATE OF BURIAL

4-13 1927

20. UNDERTAKER

J. B. Moore

ADDRESS

1120 E 18th

THIS IS A PERMANENT RECORD

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.

