JUL 26 1927

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

Do not use this space.

17906

1. PLACE OF DEATH
County: DeKalb
Township: Adams
City: Weatherby, Mo (No. ..... St. ..... Ward)
Registration District No. 263
Primary Registration District No. 4162
File No. 8
Registered No. 8

2. FULL NAME James Monroe Hudson
(a) Residence. No. Weatherby Mo 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 4th 1852

7. AGE: Years 74 | Months 7 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Elijah Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Rebecca Narl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

14. INFORMANT G. A. Hudson
(Address) 629 W-39- Kansas City Mo

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

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1927, to June 25, 1927 that I last saw h[illegible] alive on June 25, 1927, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
10 X
10 B 1010
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) infected gall bladder
(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) J. F. Hedrick, M. D
6/26, 1927 (Address) Weatherby, 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: Shambaugh Cemetery
DATE OF BURIAL: 6/27 1927

20. UNDERTAKER: [illegible]
ADDRESS: Maysville, Mo

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.

N. B.—Every item [illegible] should be [illegible] EXACTLY. PHYSICIANS should state CAUSE [illegible] may [illegible] and of OCCUPATION is very important.

C COMPLETE [illegible]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County: DeKalb — Registration District No.: 263 — File No.: 8
Township: — Primary Registration District No.: 4163 — Registered No.: 8
City: Weatherby (No. ..., ... St. ..... Ward)

2. FULL NAME: James Monroe Henderson
(a) Residence. No. ..... St., Weatherby, Mo. Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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.

AS PRESCRIBED BY LAW.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of information should be carefully supplied. AGE should be stated.

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

PERSONAL AND STATISTICAL PARTICULARS

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

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 COUNTY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 6/28 1927. J. F. Hedrick M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/25 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw b..... 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

S- 17906