SEP 26 1927

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

Do not use this space.

23540

1. PLACE OF DEATH
County Barry — Registration District No. 30 — File No.
Township — Primary Registration District No. 3003 — Registered No. 60
City Monett (No. ..... St. ..... Ward)

2. FULL NAME Ora H. Hudson
(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: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

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

7. AGE: Years 53 — Months 1 — Days 15 — If LESS than 1 day, ..... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Barry County, Mo

PARENTS
10. NAME OF FATHER: Jas. Brice Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Boone Co Ark.
12. MAIDEN NAME OF MOTHER: Virginia Frizzell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia

14. INFORMANT (Address): Mrs Jeanne Hudson Monett, Mo

15. FILED 8-8, 1927 W. M. West REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-6-1927

17. I HEREBY CERTIFY, That I attended deceased from 8-6-27, 19..., to ....., 19..., that I last saw him alive on 8-6-, 1927, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Aneurysm Right Common Carotid artery-ruptured sudden death
(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? no DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? physical examination
(Signed) [signature], M. D
8-8, 1927 (Address) Monett, 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: I.O.O.F. Cem. — DATE OF BURIAL: 8-8 1927

20. UNDERTAKER: Callaways — ADDRESS: Monett

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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: Barry — Registration District No.: 30 — File No.:

Township: — Primary Registration District No.: 3003 — Registered No.: 60

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

**2. FULL NAME** Ora B. Hudson

(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) |
|---|---|---|
| M | W | M |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-21-1874

| 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 8-8-27, 19 W. M. West
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

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.

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

SUPPLEMENTARY

5-23540