LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JAN 23 1929

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

41245

1. PLACE OF DEATH
County: Jackson — Registration District No. 402 — File No.
Township: — Primary Registration District No. 4237 — Registered No. 24
City: Oak Grove Mo (No. ... St. ... Ward)

2. FULL NAME: John Wm. 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: Male
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary Etta Hudson
6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 23-1848
7. AGE: Years 80, Months 7, Days 6 — If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(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): Jackson Co. Mo.

PARENTS
10. NAME OF FATHER: John Wm Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va
12. MAIDEN NAME OF MOTHER: Mary Wilson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Va

14. INFORMANT (Address): Arthur Alford, Oak Grove, Mo.
15. FILED 12/31, 1928 — REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 29 1928
17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to Dec. 29, 1928, that I last saw him alive on Dec. 29, 1928, and that death occurred, on the date stated above, at 7.30 p.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anemia, Pernicious
92A
106B
71B
100
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY): Chronic Bronchitis
Leakage of Tricuspid Valve of heart (duration) years mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. W. Mann, M.D.
12/30, 1928 (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: Brown Cemetry — DATE OF BURIAL: 12/31 1928
20. UNDERTAKER: Z. O. Webb — ADDRESS: Oak Grove Mo.

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

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH
County Jackson | Registration District No. 402 | File No. ......
Township ...... | Primary Registration District No. 4237 | Registered No. 24
City Oak Grove, (No. ...... St. ...... Ward)

2. FULL NAME John Wm. Hudson

(a) Residence. No. ...... St., ... 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/23/1848

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) ......

FILED 12/31 1928 A W Mann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/29 1928

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

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.

REGISTRARS SHOULD NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-4245