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

Do not use this space.

6679

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 844

Township Kaw — Primary Registration District No. 1002 — Registered No. 844

City Kansas City (No. Kansas City Genl Hosp. ..... Ward)

2. FULL NAME Hudiburg Ellen

(a) Residence. No. 4819 Indep. Ave 10 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) april 27-1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	72	9	21	

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) Galesburg (STATE OR COUNTRY) Ill

PARENTS

10. NAME OF FATHER Jeff Hudiburg

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

12. MAIDEN NAME OF MOTHER Anna Wade

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

14. INFORMANT Record Clerk (Address) K.C. Genl Hosp.

15. FILED 2-20, 1929 M M Snow Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-18 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1929 to 2-18, 1929 that I last saw her alive on 2-18, 1929 and that death occurred, on the date stated above, at 10:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of femur

186A

194B

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

CONTRIBUTORY (SECONDARY) Acute cardiac failure (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P E Williams, M. D.

2-19, 1929 (Address) Supt K.C. Genl Hosp

*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
Mt Moriah	2-20 1929
20. UNDERTAKER	**ADDRESS**
O V Mast	1915 E 15

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 844

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

2. FULL NAME Hudiburg, Ellen

(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)
F	W	S

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 7/20, 1929 M. M. Crowell REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18 1929

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:
Fracture of femur
Accidental fall in home
(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (SECONDARY) 12
(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

5-6679