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

Do not use this space. 6772

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 938
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas City (No. 5618 St John Ave St. Ward)

2. FULL NAME Mrs. Laura H. Hudson
(a) Residence. No. 5618 St John St., 10 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF John Frank Hudson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18, 1860

7. AGE: Years 68 — Months 9 — Days 8 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) Dont Know
(STATE OR COUNTRY) Virginia

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont Know
(STATE OR COUNTRY) Missouri

14. INFORMANT J. Frank Hudson
(Address) 5618 St John Ave.

15. FILED 2-26 1929 W M Crowe Registrar
Asst

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 26, 1929

17. I HEREBY CERTIFY, That I attended deceased from 20 Feb. 1929, to Feb. 25, 1929 that I last saw her alive on Feb. 25, 19..., and that death occurred, on the date stated above, at 9 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
94A
93C
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic myocarditis
(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?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. L. Ginsberg, M. D
2/26, 1929 (Address) 305 Bryant Bldg.

*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: Forest Hill — DATE OF BURIAL: 2/28/1929

20. UNDERTAKER: Freeman Mortuary — ADDRESS: 104 W. 42nd St.

WRITE PLAINLY, WITH UNFADING INK---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.

Dr. [illegible]
305 Bryant Bldg
3 to 5 –