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

Do not use this space.

19884

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 5506

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Amelia Hudson

(a) Residence. No. 2023 Chestnut St., 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 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	Negro	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-31-1895

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(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) Miss.

PARENTS

10. NAME OF FATHER James Gayles

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known.

12. MAIDEN NAME OF MOTHER Lizzie Chambers

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

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED MAY 18 1929, 19.... Wm. C. Kimberly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 16, 1929, that I last saw her alive on May 16, 1929, and that death occurred, on the date stated above, at 4:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis 131.D 150.D

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (SECONDARY) Uremia. Operation for non Malignant Fibroid of Kidneys
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-15-29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. [illegible] Thomas M.D.
5/18, 1929 (Address) City Hospital #2

*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 Greenwood Cemetery

DATE OF BURIAL 5/19 1929

20. UNDERTAKER A. S. Bell and Co.

ADDRESS 2726 Sarah

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD