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

Do not use this space.

23101

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 6555

City St. Louis Mo - 500 So. Kingshighway - Children's Hosp. St. Med. Ward

2. FULL NAME Ina Marie Hudson

(a) Residence. No. Carlyle, Ills. St., Medical Ward Carlyle Ill.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 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	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-13-20

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	9	1	5	

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

9. BIRTHPLACE (CITY OR TOWN) Arkansas
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER James Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Ethel Stewart
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Kansas

14. INFORMANT Dr Kirlick
(Address) 500 So. Kingshighway

15. FILED JUN 18 1929 Max C. Stacker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/18/ 1929

17. I HEREBY CERTIFY, That I attended deceased from 6/11/ 1929, to 6/18/ 1929 that I last saw her alive on 6/18/ 1929, and that death occurred, on the date stated above, at 10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Miliary Tuberculosis - duration ?
Acute rheumatic pericarditis - 1 mo.
Acute rheumatic myocarditis & endocarditis (duration) 0 yrs. 1 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 270
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Examination & autopsy

(Signed) A. C. Edwards, M. D.
6-18, 1929 (Address) 500 S. Kingshighway

*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 Carlyle, Ill. DATE OF BURIAL June 19 1929

20. UNDERTAKER E. J. Schmer. ADDRESS 3125 Lafayette av.

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.

261
2
31
2