

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

Do not use this space.

8595

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City (No. General Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 405
St. _____ Ward _____

2. FULL NAME

Mrs Ida F Hudson

(a) Residence. No. _____ St. _____ Ward Arkansas City - Ks
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 7 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) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb - 26 - 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 0 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9. BIRTHPLACE (CITY OR TOWN) Pushford
(STATE OR COUNTRY) New York

10. NAME OF FATHER Zephie B Metcalf

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

12. MAIDEN NAME OF MOTHER Harriet Gould

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

14. INFORMANT Mrs M. Brown
(Address) 4334 Trovok ave

15. FILED 3/3, 19 30 M. M. Cross REGISTRAR
Miss

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/1 1930

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 12:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Automobile
frustration Kc Mo
210M
1880
(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? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Autopsy Report
(Signed) Shawley M. Hall M. D.

3/1, 19 30 (Address) Deputy Coroner

*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 parsons Ks DATE OF BURIAL Mar 5 1930

20. UNDERTAKER Lawrence & Sons ADDRESS P. C. Mo.

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No. 8595
 Township..... Primary Registration District No. 1002 Registered No. 965
 City Kansas City (No.) St. Ward)

2. FULL NAME

Iida E. 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 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)

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)

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 3/3 30 M. M. Coroux REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1 - 19 30

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:

accidental automobile
trauma K.C.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE.....

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

20. UNDERTAKER

ADDRESS

19

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

SUPPLEMENTARY

1886
 200

5158