

MAY 28 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

15185

1. PLACE OF DEATH

County Worth
 Township Smith
 City Grant City, Mo.

Registration District No. 903Primary Registration District No. 621File No. 6Registered No. 6

St. _____ Ward)

2. FULL NAME

Name Kate Hudson

(a) Residence. No. _____ St. _____ Ward. _____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. _____

Ward. _____

(If nonresident, give city or town and State)

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)

 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)

PARENTS

14. INFORMANT

(Address)

15. FILED

5-10-30

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from April 16 1930
 that I last saw him alive on April 16, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infantile Spasms
11 A
 (duration) _____ yrs. _____ mos. 7 ds.
 CONTRIBUTORY (SECONDARY) Influenza
 (duration) _____ yrs. _____ mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. ✓19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physied findings(Signed) J. H. Ross M. D.4/18, 1930 (Address) Grant City, Mo.

*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

Grant City Cem.4/18 1930

20. UNDERTAKER

ADDRESS

Arch C. DungeeGrant City

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

