CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

✓ Do not use this space. 21517

~~21619~~

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City..... (No. City Hosp. #2 ..... St. ..... Ward)

File No. .....

Registered No. 6420

2. FULL NAME Leslie Hudson

(a) Residence. No. 4336A Finney St., ~~[illegible]~~ Ward. 11
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ✓ mos. ✓ ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12, 1904

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	—	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Car Washer
(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 Miles Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss
12. MAIDEN NAME OF MOTHER Sophie Bryant
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss

14. INFORMANT Gertrude Henderson
(Address) 3011 Lawton

15. FILED....., 19.. Max C. Starkloff
REGISTRAR

✓ **MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 22nd 1930

17. No Physician in Attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ..... 7/30 ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage due to Ruptured Aneurysm of Arch of Aorta
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Non Traumatic
(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M.D.

7/3, 1930 (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: Father Dickson
DATE OF BURIAL: July 3, 1930

20. UNDERTAKER: J. C. Thomas
ADDRESS: 3111 Laclede