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

Do not use this space.

38429

1. PLACE OF DEATH
County: Ste Genevieve — Registration District No.: 605
Township: Ferrand — Primary Registration District No.: 3804
City: ..... (No. ....., ... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME: Helen Allen 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: Fem.
4. COLOR OR RACE: White
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): 9-29-31

7. AGE

Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
	1	11	

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): Perryville
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Louie Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Ethel Boyd
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Mo

14. INFORMANT: Louie Hudson
(Address): Perryville Mo

15. FILED: 11/12 1931 — M. A. C. S. B. Lochman, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11-10 1931

17. I HEREBY CERTIFY, That I attended deceased from 11/7, 1931, to 11/10/31, 1931, that I last saw her alive on 11/10/31, 1931, and that death occurred, on the date stated above, at 12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107A
(duration) 1 yrs. ..... mos. 7 ds.

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

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Gregory [illegible] 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: Malden Cem. — DATE OF BURIAL: 11-11 1931

20. UNDERTAKER: Hill Bros — ADDRESS: Lilbourn 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.

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

DEC 22 1931