

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

Do not use this space.

1. PLACE OF DEATH

County Macon

Registration District No. 533

File No. 13525

Township Macon

Primary Registration District No. 3027

Registered No. 49

City Macon (No. _____)

St. _____ Ward _____

2. FULL NAME

(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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Kate Hudson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 31 - 1850

7. AGE YEARS 79 MONTHS 2 DAYS 16 If LESS than 1 day, ✓ hrs. or ✓ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retired

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Wm Hudson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.C.

MOTHER 15. MAIDEN NAME D.C.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.C.

17. INFORMANT (ADDRESS) Mrs Minnie Andrews Macon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Salem Ore DATE 4 - 18 1934

19. UNDERTAKER (ADDRESS) Stephens & Gooding Macon Mo

20. FILED May 26, 1934 Karl Claus Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 - 16 1934

22. I HEREBY CERTIFY, That I attended deceased from June 5 1933 to Apr. 16 1934

I last saw h. in alive on Apr 10 1934 Death is said to have occurred on the date stated above, at 2:55 p.m.

The principal cause of death and related causes of importance were as follows:

Uremia Date of onset Apr 10

Other contributory causes of importance:

Pyelitis no
Nephritis no

Name of operation _____ Date of _____

What test confirmed diagnosis? Urinal Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Edward Miller _____, M. D.

(Address) Macon Mo

The first part of the document discusses the general principles of the proposed system, which is designed to improve the efficiency of the government's operations. It outlines the various stages of the process, from the initial planning to the final implementation, and emphasizes the importance of maintaining accurate records throughout the entire process.

The second part of the document provides a detailed description of the proposed system, including a list of the various components and their functions. It also includes a flowchart that illustrates the overall structure of the system and the relationships between the different parts.

The third part of the document discusses the various challenges that are likely to be encountered during the implementation of the proposed system, and offers suggestions for how these challenges can be overcome. It also includes a list of the various resources that will be required for the implementation of the system, and a budget for these resources.

The fourth part of the document discusses the various benefits that are expected to be realized from the implementation of the proposed system, and offers suggestions for how these benefits can be maximized. It also includes a list of the various risks that are associated with the implementation of the system, and a plan for how these risks can be managed.

The fifth part of the document discusses the various steps that need to be taken to ensure the successful implementation of the proposed system, and offers suggestions for how these steps can be coordinated. It also includes a list of the various responsibilities that will be assigned to the various members of the implementation team, and a timeline for the implementation of the system.

The sixth part of the document discusses the various ways in which the proposed system can be evaluated, and offers suggestions for how these evaluations can be conducted. It also includes a list of the various metrics that will be used to evaluate the system, and a plan for how these metrics will be measured.

The seventh part of the document discusses the various ways in which the proposed system can be improved, and offers suggestions for how these improvements can be implemented. It also includes a list of the various areas that need to be improved, and a plan for how these improvements can be implemented.

The eighth part of the document discusses the various ways in which the proposed system can be disseminated, and offers suggestions for how these disseminations can be conducted. It also includes a list of the various channels that will be used to disseminate the system, and a plan for how these disseminations can be conducted.

The ninth part of the document discusses the various ways in which the proposed system can be maintained, and offers suggestions for how these maintenances can be conducted. It also includes a list of the various tasks that will be required for the maintenance of the system, and a plan for how these tasks can be conducted.

The tenth part of the document discusses the various ways in which the proposed system can be updated, and offers suggestions for how these updates can be implemented. It also includes a list of the various areas that need to be updated, and a plan for how these updates can be implemented.

**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 Macon
Township
City Macon (No. _____)

Registration District No. 533
Primary Registration District No. 5027

File No. _____
Registered No. 49
St. _____ Ward _____

2. FULL NAME

G.H. 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 w (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.
79 2 16

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 19 _____

Francisco
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 16 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19_____.

I last saw him alive on _____, 19_____ Death is said

to have occurred on the _____ stated above, at _____ m.

The principal cause of death, and related causes of importance were as follows:

Myocardial infarction
Chronic
Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19_____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

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

S-13525