MAY 27 1937

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

Do not use this space.

1. PLACE OF DEATH

County: Lincoln — Registration District No. 490 — File No. 16852

Township: ~~Union~~ — Primary Registration District No. 4297 — Registered No. 2

City: Silex, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Dr. Ben D. Mudd

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/26/1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	47	8	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Dentist

(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) Lincoln Co. Mo.

PARENTS

10. NAME OF FATHER Edw. Mudd

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Lincoln Co. Mo. (Cousin)

12. MAIDEN NAME OF MOTHER Hester E. Mudd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Lincoln Co. Mo.

14. INFORMANT Nona Mudd
(Address) Silex, Mo.

15. FILED 5-7-, 1937 O. H. Dawson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1937

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1937, to April 21, 1937, that I last saw h. ..... alive on April 21, 1937, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 (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? ..... DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) R. M. Jones, M. D.

, 19 (Address) Silex 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
Millwood, Mo.	4/24/37 19

20. UNDERTAKER	ADDRESS
W. R. Vorand	Silex, Mo