

RECEIVED FEB 24 1939

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

2788
Do not use this space.

1. PLACE OF DEATH 3

(a) County Knox Registration District No. 467

(b) Township Boulton Primary Registration District No. 5607

(c) City Dorothy (d) Street No. _____ St. _____

(e) Length of residence in city or town where death occurred yrs. mos. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ³²⁵ Robert Clay Hudson

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sep-26-1856

| | | | | |
|--------|-----------|----------|-----------|--|
| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, _____ hrs. or _____ min. |
| | <u>82</u> | <u>3</u> | <u>14</u> | |

OCCUPATION

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

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

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9, 1939

22. I HEREBY CERTIFY THAT I attended deceased from Jan 7, 1939, to Jan 9, 1939

I first saw him alive on Jan 9, 1939. Death is said to have occurred on the date stated above, at 2:20 P. m.

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

Uremic Poisoning

Prostatitis

Date of onset ?

Other contributory causes of importance: 10'

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinical 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) Rial W. Reynolds, M. D.

(Address) Knox City Mo

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

FATHER

13. NAME Pendleton Hudson

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

MOTHER

15. MAIDEN NAME Sallie E. Stone

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

17. INFORMANT (ADDRESS) Mrs. Thomas Greenley

Harradsburg Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Newark Cemetery DATE 1-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Keith M. Hudson

Edina Mo

20. FILED Jan 12, 1939 Frank Baldwin Local Registrar

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.

Maritta B. King

RECEIVED

District Health Officer No. 10

District File Number 10-39-66

Date Filed FEB 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.