

REC'D MAR 9 1939

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

5604

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 1007
(c) City N. C. Mo. (d) Street No. General Hospital #2 Registered No. 803
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 615 Charlotte 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (DR) WIFE OF George Price

22. I HEREBY CERTIFY, That I attended deceased from 2-9, 1939 to 2-16, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 4, 1874

I last saw her alive on 2-16, 1939. Death is said to have occurred on the date stated above, at 3:40 m. p. m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 11 12

Date of onset

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

Cerebral
Apoplexy

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fayette, Mo.

Other contributory causes of importance:

FATHER 13. NAME Geo. Washington Hudson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

Name of operation Date of

MOTHER 15. MAIDEN NAME Mary
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

What test confirmed diagnosis? Was there an autopsy? No.17. INFORMANT (ADDRESS) Pearl Price Hunter
615 Charlotte

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn DATE Indep. 2-23, 1939

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

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins Bros.
1729 Lydia

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

20. FILED 2/23, 1939 M. M. Brown
Local Registrar.

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) J. O. Brown M. D.(Address) General Hospital #2

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, _____

T. B. Watkins

_____, or by _____

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

Signed _____

T. B. Watkins

Licensed Embalmer No. 2889

P. O. Address 1729 Lydia

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.