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.

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

17242
Do not use this space.

1. PLACE OF DEATH JUN 12 1939

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1008 Registered No. 4776

or

(c) City St. Louis (d) Street No. Homer Phillips Hospital St.
(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 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Allen Hudson

(a) Residence, No. 2323 Pine St. 21
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	C	Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 17, 1918

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	20	8	5	

OCCUPATION

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

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

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

FATHER

13. NAME Robert Hudson

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

MOTHER

15. MAIDEN NAME Mary ?

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

17. INFORMANT (ADDRESS) Evelyn Hilliard 2601 N Whittier

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Washington Park DATE 5/27/39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. L. Garner 2829 Washington Ave

20. FILED MAY 26 1939 J. F. Bidwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from April 21, 1939, 19, to May 22, 1939, 19

I last saw him alive on May 22, 1939, 19 Death is said to have occurred on the date stated above, at 4:45a.m.

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

	Date of onset
Intestinal tuberculosis	4/21/39
Pulmonary tuberculosis	

Other contributory causes of importance: 23

Name of operation ..... Date of .....

What test confirmed diagnosis? clinical Was there an autopsy? yes

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) S. J. Lyman, M. D.

(Address) 2601 N Whittier

(Licensed Embalmer's Statement on Reverse Side)

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 Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

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

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