

WHILE FILLING OUT THIS FORM USE WRITING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24330
State File No. 6603
Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community _____ years, months or days

3. (a) PRINT FULL NAME 325 John Earl Hudgens
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frances Hudgens 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased About 54 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 ?? hr. min.

9. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Baker

11. Industry or business

MOTHER FATHER
12. Name Unknown Hudgens
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marie De Rouse
(b) Address Festus Missouri
17. (a) Burial (b) Date thereof 7/28/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Festus Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) JUL 27 1939 (b) J. D. Brudick
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County
(c) City or town CITY OF ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3611 N. 22 ST. 20
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 25
year 1939 hour 11:15 minute _____ A. M.
21. I hereby certify that I attended the deceased from 7/21/39
_____, 19____, to 7/25, 19____
that I last saw h im alive on 7/25
and that death occurred on the date and hour stated above.

Immediate cause of death Probable Addison's Disease
Non tubercular
Due to _____
Due to _____
Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Geo. M. Pike (M. D. or other) _____
Address City Hospital Date signed _____

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.....

Albert G. Hoff

Licensed Embalmer No.....

2921

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!