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.

REC'D SEP 12 1939

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

29166
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE
(b) Township
(c) City or SPRINGFIELD
Registration District No. 316
Primary Registration District No. 2001
Registered No. 649
(d) Street No. 1722 W. Water 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jackie Dean Hudson
(a) Residence, No. 1722 West Water St.
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 12, 1936

7. AGE: Years 3 | Months 5 | Days 9 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) Springfield
(STATE OR COUNTRY) Missouri

FATHER
13. NAME William F. Hudson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Audrey Chapman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arksanas

17. INFORMANT (ADDRESS) William F. Hudson Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hazelwood DATE Aug. 23 39

19. FUNERAL DIRECTOR (NAME) Herman Lohmeyer
(ADDRESS) Springfield Mo

20. FILED 8-22-, 1939 Chas A. George M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 8-21, 1939, to 8-21, 1939
I last saw him alive on 8-21, 1939. Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Gastro-enteritis	8/17/39
Tolerated ingestion and passage of Chicken bone (Swallowed 8-15 and passed 8-20-39)	

Other contributory causes of importance: 194 W 14

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury 8-15, 1939
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) T. Ted White, M. D.
(Address) Springfield

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

X