

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

1934
Do not use this space.

APR 17 1940

1. PLACE OF DEATH

(a) County Cape Registration District No. 125
 (b) Township Cape Primary Registration District No. 25 Registered No. _____
 (c) City Cape Girardeau or _____ (d) Street No. _____ St. _____
 (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. moa. ds.

2. PRINT FULL NAME William Howard Hudspeth

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lena E Snooker</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 25 1872</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>67</u>	<u>10</u>	<u>28</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Workman</u>			
	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) <u>St. Pleasant Mo.</u>				
FATHER	13. NAME <u>W. C. Hudspeth</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis</u>			
MOTHER	15. MAIDEN NAME <u>Elizabeth A. Scott</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis</u>			
17. INFORMANT <u>Wm. William A. Hudspeth</u> (ADDRESS) <u>St. Pleasant Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Portageville Mo.</u> DATE <u>1-24-40</u>				
19. FUNERAL DIRECTOR (NAME) <u>St. Louis Funeral Home</u> (ADDRESS) <u>Portageville Mo.</u>				
20. FILED _____ 19 _____ Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/23 1940

22. I HEREBY CERTIFY, That I attended deceased from 1/22 1940, to 1/23 1940.
 I last saw him alive on 1/22 1940. Death is said to have occurred on the date stated above, at 6:15 A.M.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
 Date of onset _____

Other contributory causes of importance: 10/5

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) G. L. Jewett M. D.
21 (Address) Cape Girardeau

STATE OF OHIO
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF HEALTH SERVICES
COLUMBUS, OHIO 43260

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1934
Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 126-
 (b) Township Cape G. Primary Registration District No. 3009 Registered No. _____
 (c) City Cape G. (d) Street No. _____
 (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 William David Hudspeth
 (a) Residence, No. PORTAGEVILLE MO. 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 m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Helen E. Smoler
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25 - 1872
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 10 28
 OCCUPATION: 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Workman
 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) Pt Pleasant Mo
 FATHER: 13. NAME C. C. Hudspeth
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn
 MOTHER: 15. MAIDEN NAME Elizabeth A. Scott
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Glen
 17. INFORMANT (ADDRESS) Mrs. William Hudspeth
Pt Pleasant Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Portageville Mo DATE 1-24-40
 19. FUNERAL DIRECTOR (ADDRESS) DeWitt Funeral Home
Portageville Mo
 20. FILED 3-8-40 J. M. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23-40
 22. I HEREBY CERTIFY, That I attended deceased from 1-22-40 to 1-23-40, 1940
 I last saw him alive on 1-22-40, 1940 Death is said to have occurred on the date stated above, at 6:15 a.m.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia Date of onset _____
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) A. P. Fugate, M. D.
 (Address) Cape Girardeau Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

