

1940 OCT 23

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32729

Registration District No. 624

Primary Registration District No. 624

Registrar's No. 5826

1. PLACE OF DEATH:

(a) County Nolaway

(b) City or town Rural Hopkins Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether)

In this community 2
years, months or days

3. (a) PRINT FULL NAME John Howell Hudson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color of race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Sept 22 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>1</u>	<u>hr.</u> <u>min.</u>

9. Birthplace Hopkins (Rural) Mo
(City, town, or county) (State or foreign country)

10. Usual occupation ✓

11. Industry or business ✓

MOTHER FATHER { 12. Name Howell Hudson

13. Birthplace Clarinda Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Inez Clymens

15. Birthplace Hopkins (Rural) Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Howell Hudson

(b) Address Hopkins Mo

17. (a) burial (b) Date thereof Sept 23 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hopkins Cem

18. (a) Signature of funeral director None

(b) Address 555

19. (a) 9/23/40 (b) O. W. Saylor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nolaway

(c) City or town Hopkins (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
year 1940 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9/22 1940 to 9/23 1940
that I last saw him alive on 9/22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intra-cranial hemorrhage

Due to difficult labor

Due to 16 1/2 hr

Other conditions 16 1/2 hr
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: ✓

Of operations ✓

Of autopsy None

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) (c) Means of injury

23. Signature C. W. Kink (M. D. or other) M.D.

Address Hopkins Date signed 9/23/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, fact should be so stated above.