

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41326**  
**4719**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3315 Wayne  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 months  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3315 Wayne  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Thomas Harry Rudd

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Jan 24 1870  
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 16 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Harper Rudd

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

14. Maiden name Ann Wynne

15. Birthplace Ky  
(City, town or county) (State or foreign country)

16. (a) Informant C. B. Rudd

(b) Address 524 W. So. Ave. Ind. Mo

17. (a) Burial (b) Date thereof 12-10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation States, Mo.

18. (a) Signature of funeral director Hill Brothers

(b) Address States - Mo.

19. (a) 12-11-40 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10<sup>th</sup>  
year 1940 hour 5 minute 18 p. M.

21. I hereby certify that I attended the deceased from Jan 1932 to Dec 10 1940  
that I last saw him alive on Dec 10 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Chronic Pulmonary Emphysema  
Due to Primary  
Other conditions 46  
(Include pregnancy within 3 months of death)

Duration  
6-70  
years

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 Robert Hill (M. D. or other)  
Address 3034 Harrison Date signed 12/11/40

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

MOTHER FATHER

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**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.**