

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.

**FILED** JAN 28 1941

Registration District No. 12

Primary Registration District No. 6104

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stone  
(b) City or town Crane  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Mary B. Hudson

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Feb 19 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation ?

11. Industry or business ?

12. Name Benny Hudson

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Rosa Elders

(b) Address Crane Mo

17. (a) Buried (b) Date thereof 11-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Mo

18. (a) Signature of funeral director W. H. Mauldin

(b) Address Crane Mo

19. (a) Nov 15-40 (b) Mrs Ethel A. Egert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17  
year 1940 hour 11 minute 45 P M.

21. I hereby certify that I attended the deceased from 1939  
to Nov-17, 1940  
that I last saw her alive on Nov-17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Heart Disease  
Definite of age

Due to \_\_\_\_\_  
Due to 94%

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

76% (Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_

23. Signature A. P. Egerton (M. D. or other) 1

Address Crane Mo Date signed 11-17-40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 141-98

Date Filed JAN 13 1947

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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.**