

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 400

Primary Registration District No. 555312

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Co Home for Aged
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo 2
(Specify whether
In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1627 Park Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME LEE HUDSON

3. (b) If veteran, name war 20 3. (c) Social Security No. no

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

6. (b) Name of husband or wife Cora Hudson 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Don't know
(Month) (Day) (Year)

8. AGE: Years 66 Months Don't know Days Don't know If less than one day min.

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

10. Usual occupation Common Laborer

11. Industry or business _____

12. Name Qualie Hudson

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

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Hudson
(b) Address 1736 madison

17. (a) Removal (b) Date thereof 2-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KC Western Dental Col

18. (a) Signature of funeral director W. Lynn + Greenstreet
(b) Address 1819 E. 19th KC Mo

19. (a) 2-17-41 (b) L. W. Booker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1941 hour 10:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from Jan. 15 1941, to Feb 8 1941;
that I last saw him alive on Feb 8 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
+ Paralysis

Due to _____
Due to 93W

Other conditions: _____
(include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy no

Duration _____
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? _____

(e) Means of injury _____
While at work? _____ (Specify type of place)

23. Signature L. W. Booker (M. D. or other) D
Address 2028 Union St Date signed 2/10/41

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

18
0
0

1132044-30

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 Edna Stewart

Licensed Embalmer No. 3836

P. O. Address 814 E 15 Ave

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.