

MAR 19 1941

Registration District No. **847**

Primary Registration District No. **6155**

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

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

**1. PLACE OF DEATH:**  
 (a) County Stone  
 (b) City or town Williams, twp.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
 In this community 21 yrs.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Stone 104  
 (c) City or town Viola  
(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.? 0 years.

**3. (a) PRINT FULL NAME** Bevelyn Louise Hudson  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Feb day 5<sup>th</sup>  
 year 1941 hour 1 minute 50 M.

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced 0  
 (b) Name of husband or wife \_\_\_\_\_  
 (c) Age of husband or wife if alive \_\_\_\_\_ years

**21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;**  
 that I last saw her alive on at birth \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**7. Birth date of deceased:** Feb 4 1941  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day 6 hr. 30 min.

Other conditions g2w  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**9. Birthplace:** Viola, Mo.  
(City, town, or county) (State or foreign country)

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**10. Usual occupation** \_\_\_\_\_  
**11. Industry or business** \_\_\_\_\_  
**MOTHER FATHER**  
**12. Name:** Harold Leo Hudson  
**13. Birthplace:** Cassville, Missouri  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** Ola Janie Keeland  
**15. Birthplace:** Stone, Co. Mo.  
(City, town, or county) (State or foreign country)

**16. (a) Informant:** \_\_\_\_\_  
 (b) Address: Viola, Missouri

**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?  
7/6! \_\_\_\_\_

**17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation McCullough

**23. Signature:** E. E. Carroll (M. D. or M. P.)  
 Address Cassville, Mo. Date signed 2/10/41

**18. (a) Signature of funeral director:** \_\_\_\_\_  
 (b) Address \_\_\_\_\_

**19. (a) \_\_\_\_\_ (b) \_\_\_\_\_**  
(Date received local registrar) (Registrar's signature)

RECEIVED

5010 2119

7-21

District Health Officer No. 0

District File Number 341-467

Date Filed MAR 13 1941

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8402

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 847

Primary Registration District No. 6152

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

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

1. PLACE OF DEATH:

(a) County Stone  
(b) City or town Williams T.P.  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Beverlyn Louise Hudson

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

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

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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 6 hr 39 min

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Feb-10 1941 (b) J. E. McDaniel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 5 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature J. E. McDaniel (M. D. or other) \_\_\_\_\_

Address Cassville Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

10/10/2008

10/10/2008