

FILLED OCT 14 1941

Registration District No. 271

Primary Registration District No. 2002

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Galena
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community _____
years, months or days) 2 days

8. (a) PRINT FULL NAME Mrs. Madeline Olive Hudson

8. (b) If veteran, name war _____ 8. (c) Social Security No. none

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

6. (b) Name of husband or wife James W. Hudson 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased Aug. 27 1911
(Month) (Day) (Year)

8. AGE: Years 30 Months 8 Days 29
If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Mr. Noah Marvin
18. Birthplace Aurora, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Edna May Wood
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. James W. Hudson
(b) Address Galena, Kansas
(Baris, cremation, or removal) (Date thereof) 9/25/41
(Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem.
 Solo Undertaking Co.

18. (a) Signature of funeral director [Signature]
(b) Address Galena, Kansas

19. (a) 9-25-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cherokee
(c) City or town Galena
(If outside city or town limits, write "RURAL")
(d) Street No. 16th and Cornwall
(If rural, give location) 2
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1941 hour _____ minute 10 A. M.

21. I hereby certify that I attended the deceased from Sept 23 to Sept 25 19 41
that I last saw her alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Myofibrils, acute
 Myocarditis
Due to Myofibrils
Due to Myocarditis
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) TRO
(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? _____

23. Signature [Signature] (Specify type of physician) (M. D. or other) _____
Address _____ Date signed _____

41-10-848

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.