

S. No. 2
M-9441
5-1-1943
X29484

14133

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 93

Primary Registration District No. 5339

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Dade, Everton Mo Rv
(b) City or town Rural - Rock Prairie Twp
(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 Mo (b) County Dade
(c) City or town Rural - Rock Prairie Twp
(If outside city or town limits, write "RURAL")
(d) Street No. Everton, Mo Rv
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Hudson

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Joseph Hudson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 14 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 9 25 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
12. Name John Rowlett 4
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace England
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Robert Hudson
(b) Address Everton R2
17. (a) Removal (b) Date thereof Mar 10 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Nebraska
18. (a) Signature of funeral director Samuel Grim
(b) Address Walnut Grove Mo
19. (a) Mar 10 43 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1943 hour 3 minute 40 P.M.
21. I hereby certify that I attended the deceased from Jan past
3 years 19 _____ to March 4th 1943
that I last saw her alive on March 4th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac De Compensation
Duration 1 1/2 yrs

Due to Hypertension Myocardial degeneration 5 yrs

Other conditions none
(Include pregnancy within 3 months of death) 930

Major findings: Of operations none
Of autopsy none

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 0
23. Signature Charles H McHaffie (M. D. or other) M.D.
Address Ash Grove, Mo Date signed 3-10-43

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

29
00

RECEIVED

District Health Officer No. 6,

District File Number 443.445

Date Filed 4/27-43

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.....

J. W. Birch

Licensed Embalmer No. 3856

P. O. Address Ash Grove Mo

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.