

S. No. 2  
-11-10-39  
3-17-39  
I 21212  
1 00

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34949

State File No. \_\_\_\_\_

NOV 12 1943

Registration District No. 150

Primary Registration District No. 05-72

Registrar's No. 130

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Rural Prairie  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Jackson County E. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community 8.2 years

3. (a) PRINT FULL NAME James Edward Tudor

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Ruth Tudor 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Dec 3 1861  
(Month) (Day) (Year)

8. AGE: 82 Years 10 Months 11 Days If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Miles Crawford Tudor

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

14. Maiden name Mary Phosp.

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

16. (a) Informant Mrs C.O. Mackey

(b) Address Lee's Summit Mo

17. (a) Burial (b) Date thereof 10-16-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Indip Mo

18. (a) Signature of funeral director N.B. Langstaff

(b) Address Lee's Summit Mo

19. (a) Oct 15-43 (b) F. M. Schick  
(Date received local registrar) (Registrar's Signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Lee's Summit  
(If outside city or town limits, write "RURAL")

(d) Street No. R# 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? no. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14. year 1943 hour 9:00 minute P.M.

21. I hereby certify that I attended the deceased from 10-10- 1943, to 10-14- 1943, that I last saw him alive on 10-13- 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Pericardi Nephritis Duration 2 yrs

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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

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 \_\_\_\_\_

23. Signature F.B. Quincy (M. D. or other) \_\_\_\_\_

Address Quorum Co Eng 205P Date signed 10/15/43

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

48000

1162

**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 *W B Langford*

Licensed Embalmer No. *3833*

P. O. Address *Leis Summit*

**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.**