

FILED AUG 2 1944  
149  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 3633 Wabash  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 33 years  
years, months or days

3. (a) PRINT FULL NAME Mrs Coy A. Hudson

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fe 5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walter D. Hudson

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Sept 2d 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56 10 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired School Teacher

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

12. Name Henry R. Wallace

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

14. Maiden name Leona E. Hickman

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

16. (a) Informant Walter D. Hudson

(b) Address 3633 Wabash Ave

17. (a) Burial (b) Date thereof 7-19-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood

19. (a) 7-18-44 (b) H. C. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 3633 Wabash Ave  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th  
year 1944 hour 8 minute P M.

21. I hereby certify that I attended the deceased from March 16, 1944, to July 16, 1944;  
that I last saw him a alive on July 16, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death: metastatic carcinoma

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

Due to Carcinoma recto sigmoid

Other conditions: 46 id  
(Include pregnancy within 3 months of death)

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

Of autopsy No

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)

23. Signature J. Montgomery (Dr. D. or other)

Address 1215 S. 1st St. Bldg. 1 Date signed 7/17/44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Dr James G. Montgomery  
Prof Bg  
Phone HA1614

**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

*Elmer E. Beck*

Licensed Embalmer No. *4063*

P. O. Address *1800 Linwood Blvd.*

**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.**