

S. No. 2
 OM-2-43
 v. 5-17-39
 X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40171

FILED JAN 4 1948

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

5177

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:
General Hospital No. 1, K.C., Mo.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Months
30 Years 1 (Specify whether
 In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1311 West 20th. St. Terrace
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ida May Hudson
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 17th
 year 1944 hour 4 minute 10 AM. M.
 21. I hereby certify that I attended the deceased from October
12th 1944 to _____ 19____
 that I last saw her alive on December 17th 1944
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Eli Hudson
 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased May ? 1870
(Month) (Day) (Year)

Immediate cause of death Bronch pneumonia
 Due to _____
 Due to _____
 Other conditions 107
(Include pregnancy within 3 months of death)

8. AGE: Years 74 Months 7.5 Days ? If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business At Home

12. Name As Lee

13. Birthplace Don't Know ?
(City, town, or county) (State or foreign country)

14. Maiden name Sarah R. Ross

15. Birthplace Don't Know ?
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address General Hospital K.C. Mo.

17. (a) Oak Grove (b) Date thereof Dec. 20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Jos. A. Butler's Sons

(b) Address 22 South 18th. St. K.C.K.

19. (a) 12-20-44 (b) N.E. Brown
(Date entered local registrar) (Registrar's signature)

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 A.E. Usher (M. D. or other) MO
 Address Gen. Hosp. Date signed _____

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

MOTHER FATHER

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. Mo. 3426

P. O. Address Kansas City, Kansas.

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.