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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39305

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11008

1. PLACE OF DEATH:
(a) County
(b) City or town St Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2819 St. Vincent Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nila Irene Hudson
3. (b) If veteran, name war No
3. (c) Social Security No. Unk
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Chester B. Hudson
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased September 3 1908 (Month) (Day) (Year)
8. AGE: Years 37 Months 3 Days 11 If less than one day hr. min.
9. Birthplace Parsons (City, town, or county) Kansas (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name George A. Carter
13. Birthplace Unknown (City, town, or county) Iowa (State or foreign country)
MOTHER 14. Maiden name Kittie M. Perkel
15. Birthplace Parsons (City, town, or county) Kansas (State or foreign country)
16. (a) Informant Chester B. Hudson
(b) Address 2819 St. Vincent Ave.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Parsons Kansas
18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.
19. (a) DEC 17 1945 (Date received local registrar) (b) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14 year 1945 hour 3:30 P minute M.
21. I hereby certify that I attended the deceased from December 11, 1945, to December 14, 1945, that I last saw her alive on December 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pentavitus
Due to
Due to
Other conditions Tuberculosis Toxic
(Include pregnancy within 3 months of death)
Major findings:
Of operations Tuberculosis observed
Of autopsy — not known

Duration

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? —
(Specify type of place)
While at work? — (e) Means of injury —
23. Signature [illegible] (M. D. or other)
Address 412 Olive Street St. Louis Date signed 12/15/45

(Licensed Embalmer's Statement on Reverse Side)

11008

11008

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. G W Wilkinson

Licensed Embalmer No. 3575

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, fact should be so stated above.