

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13181**  
Registrar's No. **1718**

Registration District No. **149** 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 Jackson City  
(c) Name of hospital or institution: General Hospital  
(d) Length of stay: In hospital or institution 1 hr 15 min  
In this community 1 year

3. (a) PRINT FULL NAME Carroll, W. Hudson  
3. (b) If veteran, name war WAR 1  
3. (c) Social Security Number Unknown

4. Sex M 5. Color of race Wh  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 31 1912  
(Month) (Day) (Year)

8. AGE: Years 33 Months 5 Days 7  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Virginia  
10. Usual occupation cook  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Lucien Hudson  
13. Birthplace Virginia  
14. Maiden name Lydian Col  
15. Birthplace Virginia  
16. (a) Informant Coroner's office  
(b) Address 122 W. 12th  
17. (a) Removal (b) Date thereof 4-11-46  
(c) Place: burial or cremation Charlottesville, Virginia  
18. (a) Signature of funeral director H. C. Bayman  
(b) Address 7406 - Normal Rd  
19. (a) 4-11-46 (b) Gertrudine Palmer

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Jackson  
(c) City or town Jackson City  
(d) Street No. 521 - E - 9  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 8  
year 1946 hour 8 minute 15 p.m.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock - Hemorrhage  
Due to Blushd left hip & pelvis  
Due to Bust + pedestrian  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 1700 1.8 21  
Of operations \_\_\_\_\_  
Of autopsy no  
History + Impression

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident 123  
(b) Date of occurrence 4-8-46  
(c) Where did injury occur? KE Jackson mo  
(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 Street Pedestrian  
33. Signature Jimm Walker (M. D. or other) \_\_\_\_\_  
Address 1429 W. 12th Date signed 4-11-46

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..... *Nancy C. Bergman*

Licensed Embalmer No..... *2041*

P. O. Address..... *100 W. 100*

**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.**