

No. 2  
12-45  
-17-39  
X47070

**FILED FEB 3 1947**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 5535 Cates Ave. 1  
(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 Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5535 Cates Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Roy Hudson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased July 21st 1896  
(Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days 2  
If less than one day hr. min.

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

10. Usual occupation SALESMAN

11. Industry or business A.S. Aloe Co.

12. Name Dr. Thomas M. Hudson

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

14. Maiden name Genevieve D. Parr

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

16. (a) Informant Mr. Gilbert Hudson

(b) Address 5535 Cates Ave.

17. (a) BURIAL (b) Date thereof 1-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perryville, Mo.

18. (a) Signature of funeral director W. J. Connelly

(b) Address 3840 Lindell Blvd.

19. (a) JAN 24 1947 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

(M. D. or other) \_\_\_\_\_

Address 607 No. Grand Date signed 1-24-47

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JAN. day 23rd.  
year 1947 hour 4 minute PM

21. I hereby certify that I attended the deceased from Aug 9 1946 to Jan 23 1947  
that I last saw him alive on Jan 22 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Rectum  
Duration about 18 mos

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

Due to H/O

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

Major findings: Carcinoma Rectum  
Of operations & obstructive Liver metastases

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

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 E. J. Jaraman (M. D. or other) \_\_\_\_\_

Address 607 No. Grand Date signed 1-24-47

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

MOTHER FATHER

DR. E. J. JAVANUX  
Univ. Club Bldg.  
12-3 pm  
Je. 9588  
No. 0792

**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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Hindell

**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.**