

Registration District No. 32

Primary Registration District No. 5714

1. PLACE OF DEATH:

(a) County Bellinger

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

(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location)

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

In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bellinger

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MOLLIE HUDSON

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 10 year 1947 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; 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 Widowed

6. (b) Name of husband or wife Frank Hudson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 18 1865 (Month) (Day) (Year)

Immediate cause of death Cardiac Respiration

Due to Hypostatic Pneumonia

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

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

8. AGE: Years 81 Months 9 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_

9. Birthplace Johnson Co. Ill (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

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

12. Name Bill Rushin

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

14. Maiden name Bessie Bill

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Allie Chambers

(b) Address 3 Alma Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 11, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Brownlee Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director Lloyd S. Morgan

(b) Address Advanced Mo

19. (a) May 3 1947 (Date received local registrar) (b) Miss H. Vandenberg (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 2

23. Signature John J. Wilson (M. D. or other) MD

Address Antietam Mo Date signed 4/24/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 547-641

Date Filed 5-6-47

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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 \_\_\_\_\_

Lloyd S. Morgan Jr, Registered Apprentice No. 430  
working under my personal supervision.

Signed Lloyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, Mo.

**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.