

FILED MAY 29 1947

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 4920

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSP NO 1 U
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 DAYS
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME DR BEN HUDSON

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife FRANCIS 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MAR 16 1861
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation DOCTOR OF M. D.

11. Industry or business _____

MOTHER FATHER { 12. Name: WILLIAM B HUDSON

18. Birthplace: GREEN Co Ill.
(City, town, or county) (State or foreign country)

14. Maiden name: AVANA KIRBY

15. Birthplace: GREEN Co. Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant: ROBERT L HUDSON

(b) Address: 5739 WATERMAN AV

17. (a) REMOVAL (b) Date thereof: 5-15-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: GIRARD, Ill

18. (a) Signature of funeral director: ROWLAND FUNERAL SERVICE

(b) Address: 4355 WASHINGTON AV

19. (a) MAY 15 1947 (b) J. F. Brudeck
(Date recorded by local registrar) (Registrar's signature)

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. 5 5739 WATERMAN AV
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 15
year 1947 hour 9:30 minute A. 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: Fracture of Right Hip; Arteriosclerosis; when he fell on the sidewalk on Apr. 30, 1947.

Due to about 4:45 P.M. while attempting to arise from sidewalk in front of his

Due to home where he had been sitting on the grass.

Other conditions (include pregnancy within 3 months of death) 186

Major findings: Of operations: 2/11

Of autopsy: _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence: Apr. 30, 1947

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Public Place

(Specify type of place) (e) Means of injury: _____

23. Signature: [Signature] (M.D. or other) _____
Address: [Address] Date signed: 5/15/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Ronald Yahrke

Licensed Embalmer No. *3917*

P. O. Address *4355 Washington*

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, above space should be left blank.