

THE DIVISION OF HEALTH OF MISSOURI  
FILED FEB 26 1949 STANDARD CERTIFICATE OF DEATH

State File No. **4404**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 28 PRIMARY REG. DIST. NO. 5365 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Davis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviness</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Melbourne, Rural, Lincoln</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Melbourne, Rural, Lincoln</u>	
c. LENGTH OF STAY (In this place) <u>10 yr</u>		d. STREET ADDRESS (If rural, give location) <u>Melbourne Missouri</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHLORA</u> b. (Middle) <u>EMMA</u> c. (Last) <u>HUDSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 6. 1949.</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 28, 1896</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>29</u>	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	11. BIRTHPLACE (State or foreign country) <u>Mount Moriah, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Robert Gleason</u>	13b. MOTHER'S MAIDEN NAME <u>Myrtle A. Phear</u>	14. NAME OF HUSBAND OR WIFE <u>John S Hudson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes, <del>World War I</del></u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John S Hudson</u>	ADDRESS <u>Melbourne Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lincoln-Daviness Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Feb-2, 1949, to Feb-6, 1949, that I last saw the deceased alive on Feb-6, 1949, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. C. Walker</u>	(Degree or title) <u>D.O. 2</u>	23b. ADDRESS <u>Gilman City Mo.</u>	23c. DATE SIGNED <u>2-7-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 9, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pilot Grove No 1</u>	24d. LOCATION (City, town, or county) (State) <u>Daviness Co Missouri</u>
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DATE REC'D BY LOCAL REG. <u>16 Feb. 1949</u>	REGISTRAR'S SIGNATURE <u>Virginia M Emulhart</u>	81	25. FUNERAL DIRECTOR'S SIGNATURE <u>W D Haines</u>	ADDRESS <u>Gilman City Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE  
Cameron, Mo.

FEB 28 1941

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 \_\_\_\_\_

*W. D. Haines*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *W. D. Haines*

Licensed Embalmer No. *949*

P. O. Address *Gilman City 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.