

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 10 1949

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 772

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural S Campbell Twp</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Brookline Township</u> | |
| c. LENGTH OF STAY (in this place) <u>1 week</u> | | d. STREET ADDRESS (If rural, give location) <u>Rural route 1, Brookline</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ozark Osteopaths Hospital</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Jon</u> | b. (Middle) <u>Paul</u> | c. (Last) <u>Hudson</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>August 26 1949</u> |
|-------------------------------------|-----------------------|-------------------------|-------------------------|---|

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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>March 18, 1945</u> | 9. AGE (In years last birthday) <u>4</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|--------------------|-------------------------------|---|--|--|------------------------|----------------------|------------------------|-----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 11. BIRTHPLACE (State or foreign country) <u>Springfield, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>William Fred Hudson</u> | 13b. MOTHER'S MAIDEN NAME <u>Audrey Chapman</u> | 14. NAME OF HUSBAND OR WIFE _____ |
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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>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs William Hudson, Brookline, Mo.</u> | ADDRESS _____ |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Toxemia</u> | | |
| | ANTECEDENT CAUSES DUE TO (b) <u>Acute gastro-enteritis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Virus infection</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Rickets</u> | | | <u>57/0</u> |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" 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) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 August 16, 1949, to August 26, 1949, that I last saw the deceased alive on 8-26, 1949, and that death occurred at 12:55 P.m., from the causes and on the date stated above.

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| 23a. SIGNATURE <u>Russell James Lynch D.O.</u> (Degree or title) <u>2</u> | 23b. ADDRESS <u>Republic, Missouri</u> | 23c. DATE SIGNED <u>8-27-49</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Aug. 28, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u> |
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| DATE REC'D BY LOCAL REG. <u>8-30-49</u> | REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeier F.H.</u> ADDRESS <u>Springfield, Mo</u> |
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Jewell E. Thuidle.....

Licensed Embalmer No. 2831.....

P. O. Address Springfield.....

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.