

FILED NOV 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34428

State File No.

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 254

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN <u>Woberly</u>		c. CITY OR TOWN <u>Vibbard</u>	
c. LENGTH OF STAY IN THIS PLACE <u>38 days</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.# 3</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wabash Hospital</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct-24-1950</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Lawrence</u> c. (Last) <u>HUDSON</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Nov-7-1898</u>		9. AGE (In years last birthday) <u>51</u> Months <u>11</u> Days <u>17</u> IF UNDER 28 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Railroad)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Switchman</u>	
11. BIRTHPLACE (State or foreign country) <u>Grana Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Martin S. Hudson</u>		13b. MOTHER'S MAIDEN NAME <u>Gertrude V. Joelle</u>	
14. NAME OF HUSBAND OR WIFE <u>Mrs. Oda Hudson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or date of service)	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Opolda Hudson</u> ADDRESS <u>Excelsior Springs Mo</u>	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>DUODENAL, FISTULA</u> ANTECEDENT CAUSES DUE TO (b) <u>PERFORATION by</u> DUE TO (c) <u>GUN SHOT WOUND.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Hypertensive Arteriosclerosis</u>	
19a. DATE OF OPERATION <u>10-18-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>DUODENAL FISTULA</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>38 days</u> <u>43 days</u> <u>Sys.</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>← YES</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>AT HOME</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Rayville Ray Missouri</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 11 1950 7p.m.</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Wife shot him E. 9 81 X</u>	
22. I hereby certify that I attended the deceased from <u>9-22</u> , 1950, to <u>10, 24</u> , 1950, that I last saw the deceased alive on <u>10 24</u> , 1950, and that death occurred at <u>NOON</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>A. Ernest Baker M.D.</u>		23b. ADDRESS <u>Wobash Employer Hospital</u>	
23c. DATE SIGNED <u>Oct. 24 '50</u>		23d. LOCATION (City, town, or county) (State) <u>Woberly Missouri</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct-24-1950</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Excelsior Springs</u>		24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs Mo</u>	
DATE REC'D BY LOCAL REG. <u>Oct 24 50</u>		REGISTRAR'S SIGNATURE <u>Peak Theelean</u>	
FURNERAL DIRECTOR'S SIGNATURE <u>Peak Theelean</u>		ADDRESS <u>Excelsior Funeral Home Woberly Mo</u>	

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

086187.730

DEC 14 1953

Date Received: OCT 31 1953
DISTRICT HEALTH OFFICE
District File Number /0-5
Date Filed: OCT 31 1953

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 _____

.....
working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *R. M. Carter*

Licensed Embalmer No. *4117*

P. O. Address *Proberly 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.