

FILED MAR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7511**

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

BIRTH NO.		REG. DIST. NO. 38	PRIMARY REG. DIST. NO. 3006	Registrar's No. 79
1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia 0105
d. FULL NAME OF HOSPITAL OR INSTITUTION Noyes Hospital		d. STREET ADDRESS (If rural, give location) 906 Hillcrest Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY		b. (Middle) HUDSON		c. (Last)
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 7, 1918		9. AGE (In years last birthday) 33		10. IF UNDER 1 YEAR: Months 0 Days 15
11. BIRTHPLACE (State or foreign country) Greensboro, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME D.G. Whitfield		13b. MOTHER'S MAIDEN NAME Blanche Proctor		14. NAME OF HUSBAND OR WIFE Charles M. Hudson Jr.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Charles M. Hudson Jr., Columbia, Mo.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Capillary cyst-adenocarcinoma of ovaries <i>Capillary Serous Cyst adeno carcinoma of ovaries</i> ANTECEDENT CAUSES <i>ovaries</i> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 weeks 6 weeks 7-1 175 x
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Inoperable tumor - Biopsied <i>Irreparable tumor - Biopsied</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 3 Feb 51 to 22 Mar 51 , that I last saw the deceased alive on 22 March 1951 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE Horace E. Thomas (Degree or title) M.D.		23b. ADDRESS Columbia, Mo.		23c. DATE SIGNED 23 Mar 51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar. 23, 1951		24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Charlotte, North Carolina		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. R.E. Palmer ADDRESS Parsons Funeral Service, Columbia, Mo.		
DATE REC'D BY LOCAL REG. Mar 23 1951		REGISTRAR'S SIGNATURE 31		

RECEIVED 3-26-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 3-26-51 _____

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 _____

Tom M. Harg

Signed.....
Student Embalmer

Licensed Embalmer No. 4067

P. O. Address Columbia 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.