

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8655

State File No.

FILED MAR 31 1953

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 5021 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>FITCHISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>FITCHISON</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>WATSON</u>)		c. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>WATSON</u>)	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location), <u>NONE</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>NONE</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>SAMUEL</u>	b. (Middle) <u>D</u>	c. (Last) <u>HUDSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3 - 24 - 1953</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>WIDOWED</u>	8. DATE OF BIRTH <u>6-12-1862</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LADDER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BLACKSMITH</u>	11. BIRTHPLACE (State or foreign country) <u>HOLT CO. MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>THOMAS HUDSON</u>	13b. MOTHER'S MAIDEN NAME <u>MELVINA UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>MARY MOATS</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>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Helen Hudson Watson</u>	ADDRESS <u>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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		MEDICAL CERTIFICATION <u>generalized arteriosclerosis.</u>	INTERVAL BETWEEN ONSET AND DEATH
	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 checked="" 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)	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 3-23, 1953, to 3-24, 1953, that I last saw the deceased alive on 3-24, 1953, and that death occurred at 10 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter Carpenter</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Rock Port Mo.</u>	23c. DATE SIGNED <u>3-25-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3-26-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>HI-CREEK</u>	24d. LOCATION (City, town, or county) (State) <u>WATSON MO</u>
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DATE REC'D BY LOCAL REG. <u>3/27/1953</u>	REGISTRAR'S SIGNATURE <u>Mabel A. Schoder</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>BARTHOLOMEW MORTUARY</u>	ADDRESS <u>Rock Port, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed Grady Bartholomew

Signed.....
Student Embalmer

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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.