

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35756

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>360</u>		PRIMARY REG. DIST. NO. <u>6225</u>		Registrar's No. <u>101</u>			
1. PLACE OF DEATH a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Washington Twp. 230 sup</u> c. LENGTH OF STAY (in this place) <u>230 sup</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Nevada State Hosp. No 3</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Greene Co.</u> c. CITY OR TOWN <u>Springfield</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>1101 W. Calhoun St</u>					
3. NAME OF DECEASED a. (First) <u>Mortha</u> b. (Middle) <u>El</u> c. (Last) <u>Hudson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-21-55</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>3-10-1876</u>		9. AGE (in years last birthday) <u>79</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>		11. IF UNDER 18 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, specify revised) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>			11. BIRTHPLACE (City and State or Foreign Country) <u>Wright Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Henry J. Fralick</u>			13b. MOTHER'S MAIDEN NAME <u>Angeline Cooper</u>			14. NAME OF HUSBAND OR WIFE <u>B. F. Hudson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ed M. Payne</u> ADDRESS _____				
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* <u>Coronary Vessel Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebrovascular Disease</u> DUE TO (c) <u>H201</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Brain Syndrome with Dry chest</u>					INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u>	
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION _____			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 <u>Sept 28, 1955</u> , to <u>Oct 21, 1955</u> that I last saw the deceased alive on <u>Oct 21, 1955</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Edmund J. Payne, M.D.</u>			23b. ADDRESS <u>State Hospital #3-Nevada, Mo</u>			23c. DATE SIGNED <u>10-21-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>21 Oct. 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri.</u>			
DATE REC'D BY LOCAL REG. <u>10-22-55</u>		REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Fred C. Thieme, Springfield, Mo.</u>					

WRITE PLAINLY—USING UNEADING 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..

Student.....  
Signature of Student Embalmer

Signed *Ralph H. Thieme*.....

Licensed Embalmer No... 3681  
Springfield,  
P. O. Address Missouri.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.