

Health, Welfare, Public Service

300 7-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30011

STATE FILE NUMBER

FILED OCT 2 1956

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 249

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>RANDOLPH</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MOBERLY</u> <u>D883</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSPITAL # 1</u> Length of stay in lb <u>6101</u>		d. STREET ADDRESS <u>NONE</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BEULAH</u> Middle <u></u> Last <u>HUDSON</u>			4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>56</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>56</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>MACON COUNTY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM L. HUDSON</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE LUCAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>STATE HOSPITAL # 1, FULTON, MISSOURI</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL DILATATION</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. Death occurred at <u>STATE HOSPITAL # 1</u> on <u>11-17-37</u> to <u>9-25-56</u> and last saw <u>XXXXXXXXXXXXXXXXXXXXXXXXXXXX</u> Death occurred at <u>1:15 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>T. D. McCarthy</u> (Print or title)		22b. ADDRESS <u>STATE HOSPITAL # 1, FULTON, MO.</u>	22c. DATE SIGNED <u>9-25-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept 26 56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia MO</u>
24. FUNERAL DIRECTOR <u>J. O. Roberts</u> ADDRESS <u>Columbia MO</u>		25. DATE RECD. BY LOCAL REG. <u>9/26/56</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Anatomical Board  
Columbia Missouri

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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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.