

Health,  
, & Welfare  
S. Public  
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v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44414

STATE FILE NUMBER 5857

FILED JAN 8 1958

Registration District No. 149 Primary Registration District No. 1202 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	568 CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) <b>VA HOSPITAL</b>			Length of stay in 1b <b>1 1/2 years</b>	d. STREET ADDRESS <b>3108 BENTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>W.</b> Last <b>HUDSON</b>				4. DATE OF DEATH <b>December 11, 1957</b> Month <b>December</b> Day <b>11</b> Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/3/33</b>		9. AGE (In years last birthday) <b>24</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Purcell, Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Ollie HUDSON</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Cleveland</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes PL 28</b>			16. SOCIAL SECURITY NO. <b>447-30-4920</b>		17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>							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) <b>Chronic glomerulonephritis</b>		592X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>								
20d. INJURY OCCURRED WHILE AT <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. Attended the deceased from <b>November 24, 1957</b> to <b>December 11, 1957</b> Death occurred at <b>6:05 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>E. F. FOROUGH, M.D.</b>				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>12/11/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec. 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Purcell, Oklahoma</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mrs. Meek's Mortuary, K. C. MO.</b>			25. DATE RECD. BY LOCAL REG. <b>12-12-57</b>		26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION



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 *Millard B. Paskin*  
 \_\_\_\_\_, Licensed Embalmer No. 5013  
 P. O. Address N. C. Md.

**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 *Millard B. Paskin*  
\_\_\_\_\_

\_\_\_\_\_, Licensed Embalmer No. 5013  
P. O. Address N. C. Md.

**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.