

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 8 1960

'59 0 4 5 5 7 6

211970

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4161 St. Louis</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Romey</b> Middle Last <b>Hudson</b>	4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>59</b>
---	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-3-1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Westpoint, Miss.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	-----------------------------------	---	--

13a. FATHER'S NAME <b>Cornelius Hudson</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Stanley Hudson</b>	Address <b>1390 Clara</b>
--	-------------------------	--	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CVA</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pulmonary Embolism</b>	
	DUE TO (c)	<b>331x</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ Month, Day, Year _____ a.m. p.m.
---

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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo</b>
--	--	--	----------------------------	--------------------

21. I attended the deceased from <b>12-5-59</b> to <b>12-22-59</b> and last saw him alive on <b>12-22-59</b> Death occurred at <b>10:00</b> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <b>Merle B. Sherford M.D.</b>	Degree or title	22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>12-26-59</b>
---	-----------------	---	-------------------------------------

23a. BURIAL, CREMATION, APPROVAL (Specify) <b>Burial</b>	23b. DATE <b>12-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>5500 Brown Rd. Mar</b>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <b>E. Boyd</b>	ADDRESS <b>3704 Finney</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 26 1959</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
--	-------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. Claude Gos

Licensed Embalmer No. 348

P. O. Address 1123 N

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.