

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032914

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4267

STATE FILE NUMBER

FILED SEP 20 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 65 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. Lukes Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4536 Summitt Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BRENT Middle C. Last HUDSON			4. DATE OF DEATH Month August Day 26 Year 1961	
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5. SEX MALE	6. COLOR OR RACE Cauc.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1897	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Nevada, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME HENRY HUDSON	13b. MOTHER'S MAIDEN NAME JANE NEWELL	14. NAME OF HUSBAND OR WIFE Effie HUDSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Effie HUDSON Address 4536 Summitt
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 8 hours
DUE TO (b) arteriosclerotic coronary thrombosis		
DUE TO (c) arteriosclerotic heart disease		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture left femoral neck	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
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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.)
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20c. TIME OF INJURY Hour 9:05 a.m. PM Month, Day, Year August 23, 1961

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 Summitt COUNTY Jackson STATE Missouri
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21. I attended the deceased from **August 23, 1961** to **Aug. 26-61** and last saw her/him alive on **August 26-61**
Death occurred at **9:05 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John M. Singleboon MD	22b. ADDRESS 2500 JOHNSON DRIVE SHAWNEE MISSION, KANSAS	22c. DATE SIGNED 8/28/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23d. LOCATION (City, town, or county) Kansas City Missouri
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Funeral Director Muehlebach ADDRESS 6500 TROOST	25. DATE RECD. BY LOCAL REG. 8-28-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JOHN M. SINGLEBOON

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. (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.