

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-040111**

STATE FILE NUMBER

Filed **NOV 20 1961** Primary Registration District No. **3006** Registrar's No. **693**

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in lb <b>8 days</b>	c. CITY OR TOWN <b>Hallsville</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>-----</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mollie E. Hudson</b>			4. DATE OF DEATH Month Day Year <b>11 12 1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/1876</b>
9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Boone County, Mo.</b>
13a. FATHER'S NAME <b>Michael Harrigan</b>		13b. MOTHER'S MAIDEN NAME <b>Melissa J. Rouse</b>	14. NAME OF HUSBAND OR WIFE <b>William Hudson (Dec.)</b>
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. <b>-----</b>	17. INFORMANT <b>Velva Walker Kansas City, 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>Encephalomalacia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral artery sclerosis</b>			} <b>unb- rown</b>
DUE TO (c) <b>advanced generalized sclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>arteriolar nephrosclerosis with uremia</b>			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 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. I attended the deceased from <b>29 Oct 61</b> to <b>death</b> and last saw <sup>her</sup> alive on <b>day of death</b> Death occurred at <b>2:45</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Elvie P. Rodgers, M. D.</b>		22b. ADDRESS <b>210 So. Tenth</b>	22c. DATE SIGNED <b>13 Nov 61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/14/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Boone County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Lyman Sprinkle Columbia, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 14 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>

**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

*Lynnan H. Spunkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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.