

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032781

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 305 STATE FILE NUMBER

DO NOT WRITE ON THIS STUD AMENDED

<b>FILED SEP 4 1963</b>							
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Lawrence</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b> Length of stay in 1b <b>396 days</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> c. CITY OR TOWN <b>Ash Grove</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS <b>Box 19</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>Nathan</b> Last <b>Hudson</b>							
<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>24</b> Year <b>1963</b>							
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-24-10</b>	<b>9. AGE (last birthday)</b> <b>53</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <b>Florence, Kansas</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>	
<b>13a. FATHER'S NAME</b> <b>John William Hudson</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Emma Ainsworth</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Mabel Hudson</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <b>Mrs Mabel Hudson</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale with congestive failure</b> 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 (a) <b>Pulmonary tuberculosis, far advanced. Silicosis.</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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>7-23-62</u> to <u>8-24-63</u> and last saw <sup>him</sup> <del>her</del> alive on <u>8-24-63</u> Death occurred at <u>10:55 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22. SIGNATURE</b> (Degree or title) 			<b>22b. ADDRESS</b> <b>Mo. S. S., Mt. Vernon, Mo.</b>		<b>22c. DATE SIGNED</b> <b>8-24-63</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>8/27/1963</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Old Branson Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Branson, Mo</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Walter Cobb Branson, Mo</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-25-63</b>		<b>26. REGISTRAR'S SIGNATURE</b> 		

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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: Walter Bell

Licensed Embalmer No. 4731

P. O. Address: Branson Mo

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.

2102