MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18863

1. PLACE OF DEATH
County Carroll — Registration District No. 135
Township — Primary Registration District No. 3940
City Carrollton — No. 615 — North Jefferson St. — File No. — Registered No. 60 — Ward

2. FULL NAME Rufus Bedford Hudson

(a) Residence. No. 615 North Jefferson St., 1st Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) ~~WIFE OF~~ Kate Hubbel Hudson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-24-1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Carroll Co
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Rufus Bedford Hudson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Katherine Drear
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unguessed

14. INFORMANT W E Hudson
(Address) Carrollton Mo

15. FILED 6-25-1930 Mrs E E Farnham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-24-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-10-30, 19..., to 6-24-30, 19..., that I last saw him alive on 6-24-30, 19..., and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interstitial Nephritis
Mitral Regurgitation
(duration) ...yrs...mos...ds.
CONTRIBUTORY (SECONDARY) 1290
(duration) ...yrs...mos...ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) L M Duncan, M. D.
6/25, 1930 (Address) Carrollton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Cemetery — DATE OF BURIAL 6/26 1930
20. UNDERTAKER Wells Funeral Home — ADDRESS Carrollton Mo

Item of information should be carefully supplied. Any should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Carroll — Registration District No. 135 — File No.
Township — Primary Registration District No. 7 & 10 — Registered No. 65
City Carrollton (No. , St. , Ward)

2. FULL NAME Reppas Bedford Hudson

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-24-1859

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.
INFORMANT
(Address)

15. FILED 6-25 1930 Mrs E E Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1930

17.
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every ... of information should be carefully supplied. AGE ... be stated EXACTLY. PHYSICIANS should state CAUSE OF ... IN plain terms, so that it may be properly classified. ... exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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