

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

Do not use this space.

40728

**PLACE OF DEATH**

County Henry  
Township Windsor  
City Windsor (No. ....)

Registration District No. 14  
Primary Registration District No. 4211

File No. ....  
Registered No. 33 St. .... Ward)

**2. FULL NAME** Frank R. 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 25 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
51 7 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. salesman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....  
1931 7

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME James Hudson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Martha Allan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Mrs. Frank R. Hudson  
(ADDRESS) Windsor Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Laurel Oak DATE Dec. 8 1931

19. UNDERTAKER Windsor Missouri  
(ADDRESS)

20. FILED Dec 8 1931 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 6 1931

22. I HEREBY CERTIFY, that I attended deceased from Dec 3 1931 to Dec 6 1931

I last saw live on Dec 4 1931. Death is said to have occurred on the date stated above, at 6 P.M.

The principal cause of death and related causes of importance were as follows:

Heart disease (Sudden) Date of onset

Other contributory causes of importance: 95A 95W

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....  
(Signed) T. J. [Signature] M. D.  
(Address) [Address]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 Henry Registration District No. 14  
Township \_\_\_\_\_ Primary Registration District No. 4211  
City Windsor (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 33  
St. \_\_\_\_\_ (Ward) \_\_\_\_\_

**2. FULL NAME**

Frank P. 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 10, 1880</u>		
7. AGE	YEARS <u>51</u>	MONTHS' <u>9</u> DAYS <u>25</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		11. Total time (years) spent in this occupation.
10. Date deceased last worked at this occupation (month and year)		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 6, 1931  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the day stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset
Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Y

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____, 19____
19. UNDERTAKER (ADDRESS)
20. FILED _____, 19____

*[Signature]*  
Registrar

Every item of information should be carefully supplied. (Age should be stated EXACTLY. PHYSICIAN'S STATEMENT OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms. ARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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