

FILED JAN 17 1944

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **45**

1. PLACE OF DEATH:

(a) County **ST. Louis**
(b) City or town **KOCH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ROBERT KOCH HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **40 DAYS**
(Specify whether years, months or days) **40 DAYS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **ST. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3900 W. BELL**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **BEATRICE VELMA DUDLEY**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **2**

4. Sex **FEMALE** 5. Color or race **COLORED** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JOHN DUDLEY** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **SEPTEMBER 2, 1896**
(Month) (Day) (Year)

8. AGE: Years **47** Months **4** Days **-** If less than one day **-** hr. **-** min.

9. Birthplace **JEFFERSON CO. ARK.** (City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **JOSEPH CAIN**
13. Birthplace **NEW ORLEANS LA.** (City, town, or county) (State or foreign country)
14. Maiden name **PEARL WESSON**
15. Birthplace **FORTH SMITH ARK.** (City, town, or county) (State or foreign country)

16. (a) Informant **PATIENT**

(b) Address **ROBERT KOCH HOSPITAL**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **1-10-44** (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **J. H. Randle P. Son**

(b) Address **3133 Bell Ave**

19. (a) **JAN 10 1944** (Date received local registrar) (b) **E. G. McHarran, M.D.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **9** year **1944** hour **6** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **NOVEMBER 23**, 19**43**, to **JANUARY 2**, 19**44**; that I last saw h. **EA** alive on **JANUARY 2**, 19**44**; and that death occurred on the date and hour stated above.

Immediate cause of death **PULMONARY T.B.C.** Duration **1 YEAR?**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **13 ft** Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Bernard Friedman** (M. D. or other) **M.D.**

Address **Koch Hosp., Koch, Mo.** Date signed **1-2-43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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

Registered Apprentice No.

working under my personal supervision.

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 this body is not embalmed, fact should be so stated above.