

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008623  
STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. 373 Primary Registration District No. 6268 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NIANGUA T.S.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>NIANGUA MO. R.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>SMI E NIANGUA</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JIM</u> Middle <u>DUDLEY</u> Last <u>DUDLEY</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 22 1873</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET FARMER</u>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
10c. FATHER'S NAME <u>GABRIEL DUDLEY</u>		10d. MOTHER'S MAIDEN NAME <u>MARY BARNER</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. NAME OF HUSBAND OR WIFE		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>CLARICE ALEXANDER MARSHFIELD</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO (b) <u>acute Bronchitis &amp; cough.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u> <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>			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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 <u>Jan 13, 1958</u> to <u>Feb. 12, 1958</u> and last saw <sup>her</sup> alive on <u>Jan 23, 1958</u> . Death occurred at <u>11:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. M. Macdonnell MD</u>		22b. ADDRESS <u>Marshfield, Mo.</u>	
22c. DATE SIGNED <u>March 1, 1958</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COPENING</u>	23d. LOCATION (City, town, or country) (State) <u>WEBSTER Co Mo</u>
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u>		25. DATE RECD. BY LOCAL REG. <u>3-4-58</u>	26. REGISTRAR'S SIGNATURE <u>J. Francis</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

lth,  
ffare  
lic  
vice

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All diseases in Part I must be causally related.

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 *Paul Boyler* .....

Licensed Embalmer No. *3848* .....  
P. O. Address *Wm. Lowe 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.