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

PLACE OF DEATH

County Montgomery

Township or Village

City Montgomery (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 592 File No. 25351

Primary Registration District No. 4350 Registered No. 21

FULL NAME R. C. Hudson

PERSONAL AND STATISTICAL PARTICULARS		
SEX: M	COLOR OR RACE: W	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
DATE OF BIRTH: March 4, 1831 (Month) (Day) (Year)		
AGE: 84 yrs. 5 mos. 20 ds.		If LESS than 1 day, ... hrs. or ... min.?
OCCUPATION (a) Trade, profession, or particular kind of work: Retired		131
(b) General nature of industry, business, or establishment in which employed (or employer)		153
BIRTHPLACE (City or town, State or foreign country): Warren Co MO		
PARENTS — NAME OF FATHER: Don't Know		
BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know		
MAIDEN NAME OF MOTHER: Don't Know		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Owings

(ADDRESS) Montgomery City MO

Filed Aug. 26 1915 E.W. Tinsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 24, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1914, to Aug 24, 1915, that I last saw him alive on Aug. 24, 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Heart failure - Pityriasis Rubra or Dermatitis Exfoliativa Universale

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

(Signed) David Nowlin M. D.

Aug. 25 1915 (Address) Montgomery City - Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Montgomery City Cemetery — DATE OF BURIAL: 8/26 1915

UNDERTAKER: C W Hopkins — 7 1487 — ADDRESS: Montgomery MO

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.

PERMANENT RECORD

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

PLACE OF DEATH

County ______

Township ______ or Village ______ or City ______ (NO. ______ St.; ______ Ward)

Registration District No. ______ File No. ______

Primary Registration District No. ______ Registered No. ______

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ______

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE / MARRIED / WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ______, 1______ (Month) (Day) (Year)

AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ______
(b) General nature of industry, business, or establishment in which employed (or employer) ______

BIRTHPLACE (City or town, State or foreign country) ______

PARENTS
- NAME OF FATHER ______
- BIRTHPLACE OF FATHER (City or town, State or foreign country) ______
- MAIDEN NAME OF MOTHER ______
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ______

(ADDRESS) ______

Filed ______, 191___, ______ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ______, 191___ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ______, 191___, to ______, 191___,

that I last saw h___ alive on ______, 191___,

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.

(Signed) ______ M. D.

______, 191___ (Address) ______

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ______, 191___
UNDERTAKER	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.