

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.

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

6588
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 186
 (c) City Springfield (d) Street No. 2504 N. Broadway St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in above town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME WILLIAM O. LA-RUE

(a) Residence, No. 2504 N. Broadway St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Mattie M. LaRue
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 6-1881
 7. AGE YEARS 57 MONTHS 7 DAYS 26 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Boiler maker
 9. Industry or business in which work was done, as saw mill, bank, etc. Frisco R.R. Shops
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2, 1939
 22. I HEREBY CERTIFY, That I attended deceased from indeed, 19....., to....., 19....., 19.....
 I last saw indeed alive on March 2, 1939. Death is said to have occurred on the date stated above, at 6:00 a.m.
 The principal cause of death and related causes of importance, were as follows:

Angina Pectoris

Date of onset

Other contributory causes of importance:

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

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Mattie M. LaRue Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE March 3, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Huggins & Co. Springfield Mo.

20. March 3, 1939 Chas. A. Huggins Local Registrar

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

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) W. H. Huggins M. D. (Address) 604 E. Elm

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 *Roy A. Cairns*

Licensed Embalmer No. *1763*

P. O. Address *Springfield*

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, above space should be left blank.