

S. No. 2
M-5-42
5-17-39
PI X32673

Dr. Maddox

37784

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED NOV 24 1944

Registration District No. 28

Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**

(a) County..... **Springfield**

(b) City or town..... **Springfield**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. John's Hosp.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Months**
(Specify whether years, months or days)

In this community **30 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Phelps**

(c) City or town..... **Rolla**
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Florence Wear LaRue**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **5** year **1944** hour **6** minute **45** a. M.

21. I hereby certify that I attended the deceased from **8-25** 19**44** to **11-5** 19**44** that I last saw h. **e.r.** alive on **11-5** 19**44** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Westley LaRue** 6. (c) Age of husband or wife if alive **40 1/2** years

7. Birth date of deceased **Nov. 25, 1910**
(Month) (Day) (Year)

Immediate cause of death **Thrombophlebitis - migratory** **3 Mo** Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

8. AGE: Years Months Days If less than one day

33 **11** **10** hr. min.

9. Birthplace **Springfield Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **Hunter Wear**

{ 13. Birthplace **Cooper County Missouri**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Ella Ford**

{ 15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Stillwagen**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **11/8/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary**

18. (a) Signature of funeral director **H.H. Lohmeyer**

(b) Address **Springfield, Mo.**

19. (a) **11-8-44** (b) **Dr. W. J. Daudley**
(Date received local registrar) (Registrar's signature)

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 **Dr. P. Maddox** (M. D. or other)

Address **Springfield, Mo.** Date signed **11-6-44**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Walter E. Hamillan*

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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 this body is not embalmed, fact should be so stated above.