S. No. 2
M—8-43
. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12678

Registration District No. 10
Primary Registration District No. 3002
Registrar's No. 59

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

4
1
2

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1120 So Jefferson St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 14 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Audrain 4
(c) City or town Mexico 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hallie LuRue Adams
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 17th 1863
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
81	7	26	hr. min.

9. Birthplace Ewing Mo
(City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name George W LaRue
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary H Ashcraft
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ben Langanbach
(b) Address Mexico Mo
17. (a) Burial (b) Date thereof 4/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Westminster Cemetery
18. (c) Signature of funeral director Million & Barkelew
(b) Address Shelbina Mo
19. (a) 4-14-1945 (b) Margaret H Mackie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13th day April
year 1945 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov-12 44, 19 , to Apr 13, 1945
that I last saw her alive on Apr 12-45, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Neck of femur - Due to fall - | Duration
Due to Hemiplegia Jan 2-45-
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

186 4

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) accident 04
(b) Date of occurrence Nov-12-44 01
(c) Where did injury occur? Home Mexico Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place)
While at work? No (e) Means of injury fell on kitchen floor
23. Signature R W Van Wyngarden (M.D. or other) D.O.
Address Mexico Mo Date signed 4-14-45

1294

(Licensed Embalmer's Statement on Reverse Side)

935W

RECEIVED
District Health Officer No. 10
District File Number 5-45-85
Date Filed MAY 10 1945

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 Doug C Dankelew

Licensed Embalmer No. 3835

P. O. Address Shelburne, Vt

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.