No. 2
-9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 28 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3665

Registration District No. 278

Primary Registration District No. 3054

Registrar's No.

1. PLACE OF DEATH
(a) County Pike
(b) City or town Louisiana (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community More than 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike 82
(c) City or town Louisiana (If outside city or town limits, write "RURAL") 2
(d) Street No. 1009 Iowa (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lucy C Angle
3. (b) If veteran, name war Nil
3. (c) Social Security No. none

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 6/15 (Month) 1860 (Day) (Year)

8. AGE: Years 85 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Pike Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Home
11. Industry or business None
12. FATHER Name Wm Shreck
13. FATHER Birthplace (City, town, or county) Penn (State or foreign country)
14. MOTHER Maiden name Nancy Todd
15. MOTHER Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant Mrs Ruby Angle Phebe
(b) Address Louisiana Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (Month) (Day) (Year)
(c) Place: burial or cremation Riverview Cemetery
18. (a) Signature of funeral director Haley Mortuary
(b) Address Louisiana Mo
19. (a) 12/12/45 (Date received local registrar) (b) Marguite Stephens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10 year 1945 hour 9 minute 30 P.M.
21. I hereby certify that I attended the deceased from Nov 9, 1945, 19 to Dec 9, 1945, 19 that I last saw h[e] alive on Dec 10, 1945, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 wks
Due to: Chr. Hypertension, chr. Arteriosclerosis	?
Due to:	
Other conditions (Include pregnancy within 3 months of death): Hemiplegia (Right)	3 wks

Major findings:
Of operations None
Of autopsy None

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)
(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? (Specify type of place)
While at work Means of injury

23. Signature Robert L. Andrae M.D. (M. D. or other)
Address Louisiana Mo. Date signed 12/14/45

(Licensed Embalmer's Statement on Reverse Side)

ROBERT L. ANDRAE, M. D.

255

RECEIVED
District Health Officer No. 10
District File Number 1-46-165
Date Filed JAN 24 1946

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.....
George O. Wagner, Registered Apprentice No.....
working under my personal supervision.

Signed George O. Wagner
Licensed Embalmer No. 3793
P. O. Address Lousiana, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.