o. 2
/47
7-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 8 1947

Registration District No. 749

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27773
Registrar's No. 3665

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.C.Hospital No.1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 9 days (Specify whether years, months or days)
In this community: 8 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 3329 Troost Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

48
3
8

3. (a) PRINT FULL NAME: Maud LaRue
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Arthur La Rue
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept (Month) 20 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
57	11	4	hr. min.

9. Birthplace: Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business:
FATHER
12. Name: Phillip Musgrove
13. Birthplace: Arkansas (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Sarah Barnes
15. Birthplace: Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant: Carl J. LaRue
(b) Address: 3329 Troost Ave.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Texarkana, Texas
18. (a) Signature of funeral director: Weilert Funeral Home
(b) Address: Kansas City, Missouri
19. (a) 8-26-47 (Date received by local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 24th
year: 1947 hour: 6:00 P.M. minute: M.
21. I hereby certify that I attended the deceased from 8-15-47, 19..., to 8-24-47, 19...; that I last saw her alive on 8-24-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Tongue	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

PHYSICIAN
Underline the cause of 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? (e) Means of injury:
23. Signature: Wm. H. Hart (M. D. or other) M.D.
Address: Dir. K.C.Gen.Hospital K.C.Mo. Date signed:

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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 Blaine E. Weibert

Licensed Embalmer No. 4075

P. O. Address K.C. 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.