

Dr La Rue

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12066

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
1-56

securing the medical certification in the specific manner required by 195.140-140.145. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 18 1957

Registration District No. 27 Primary Registration District No. 5096 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <b>Bates</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Pleasant Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>0070</b> <b>0</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pine Tree Rest Home</b>		Length of stay in 1b <b>Home</b>	d. STREET ADDRESS <b>Pine Tree Rest Home</b> <b>Mt. Pleasant Twp.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Orie VanRiette.</b>			4. DATE OF DEATH <b>Mar. 30, 1957.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1865</b>		9. AGE (In years last birthday) <b>91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Belgium.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John VanRiette</b>			14. MOTHER'S MAIDEN NAME <b>Amelia ? ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Tracy California.</b> <b>Mrs. Mark Shaw, R. #2 Box 381.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremic coma, circulatory collapse</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.					
DUE TO (b) <b>Chronic pyelonephritis</b>					<b>10 years</b>
DUE TO (c) <b>destruction of kidney elements</b>					<b>18 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Nov. 10-1956</b> to <b>March 30 '57</b> and last saw <sup>him</sup> alive on <b>Mar. 30-57</b> Death occurred at <b>6:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>L. S. La Rue, M.D.</b>			22b. ADDRESS <b>Butler, Mo</b>		22c. DATE SIGNED <b>4-1-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-2-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rich Hill, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Six Funeral Service, Adrian, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Apr. 13-1957</b>		26. REGISTRAR'S SIGNATURE <b>Rendell Kusey</b>	

17-0

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 .....; Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed ..... 

Licensed Embalmer No. 3650

P. O. Address ..Adrian, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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