

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010599  
State File No. ....

FILED MAR 17 1958

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 179 PRIMARY REG. DIST. NO. 5673 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u> c. CITY OR TOWN <u>570</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural Monroe</u> ) c. LENGTH OF STAY (In this place) <u>10 yr.</u>		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7 Miles East of Troy MO.</u>		e. STREET ADDRESS (If rural, give location) <u>7 Mi. East of Troy MO.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Meredith</u> c. (Last) <u>LaRue</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 4, 1958</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>	8. DATE OF BIRTH <u>April 17, 1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Troy MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles LaRue</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Segrass</u>	14. NAME OF HUSBAND OR WIFE <u>Susie LaRue</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Richard LaRue</u> ADDRESS <u>Troy MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>1. Cerebral apoplexy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>334X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>2</u>
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22. I hereby certify that I attended the deceased from 6/2, 1957, to Mar 4, 1958, that I last saw the deceased alive on 3-4-, 1958, and that death occurred at 9.00P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>Troy Mo</u>	23c. DATE SIGNED <u>3/5/58</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 7, 1958</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Gililee Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lincoln County MO.</u>
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DATE REC'D BY LOCAL REG. <u>3-14-58</u>	REGISTRAR'S SIGNATURE <u>Nell G. Schoenhein</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Mc Coy</u> ADDRESS <u>Troy Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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... *D. W. Mc Coy* .....

Licensed Embalmer No. *3584*.....

P. O. Address... *Troy 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.