

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006766

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 34

300

-57

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY OR TOWN <u>St. Charles</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Charles</u> <sup>0923</sup>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>819 S. Benton</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>S.</u> Last <u>La Rue</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>5,</u> Year <u>1959</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Month <u>5</u> Day <u>1</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>Custodian</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and state or country) <u>Lincoln County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Squire De Rue</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Segrass</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Tucker LaRue</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>497-01-5825</u>	17. INFORMANT <u>Mrs Mary Croquart, St. Ann's, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary Arteriosclerosis</u>		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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 <u>St. Charles</u>	COUNTY <u>St. Charles</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>Feb 5, 1959</u> and last saw her alive on <u>Feb 5, 1959</u> Death occurred at <u>8:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. M. [Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>1175 [Address]</u>	22c. DATE SIGNED <u>Feb 7, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Galilee Church Com.</u>	23d. LOCATION (City, town, or county) (State) <u>Winfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>Arthur C. Bauo, St. Charles, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>FEB 8 - 59</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

6961 02 1959

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 *David C. Paul* .....

Licensed Embalmer No. *5060* .....

P. O. Address *St Charles, 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.