

FILED JAN 16 1945

Primary Registration District No. 2001

Registrar's No. 620

1. PLACE OF DEATH:

(a) County JASPER

(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 307 W. "A" St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 21 yrs.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Joplin
(If outside city or town limits, write "RURAL")

(d) Street No. 307 W. "A" St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Milas Jay Rue

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Frances Rue 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased March 25 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Frove Springs Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name John Rue

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Delpha Overland

15. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sarah Frances Rue

(b) Address 307 W. "A"

17. (a) Burial (b) Date thereof Jan 2-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ozark Memorial

18. (a) Signature of funeral director Thornhill-Dillon

(b) Address 305 W. 4th Joplin

19. (a) 12-29-44 (b) Arthur S. Scholte
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26 year 1944 hour 8 minute 4 M.

21. I hereby certify that I attended the deceased from 4-9-43 _____, 19____, to 12-26- _____, 1944;

that I last saw him alive on 12-26 _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis
Ch. Indociditis
Senile dementia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 3 1/2

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature Arthur S. Scholte (M. D. or other) MD

Address: 1229-44 Date signed 1/28

Duration _____

Physician _____

Underline the cause to which death should be charged statistically.

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

12040

44-12-1063

JAN 22 1945

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 *Cecil A Thornhill*

Licensed Embalmer No. *3590*

P. O. Address *Joplin 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.