

No. 300
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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED OCT 6 1948

Registration District No. 170

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5636

State File No. 10-78-112

Registrar's No. 109

No. 30237

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

1. PLACE OF DEATH:

(a) County Wagler
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
Washington
(c) Name of hospital or institution:
Gravesprings Rd. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 79 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wagler 53
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Gravesprings Rd.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARLENA ELIZABETH RUE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 25
year 1948 hour 8 minute 45 P.M.
21. I hereby certify that I attended the deceased from July 8, 1948, to Sept 25, 1948,
that I last saw her alive on Sept 10, 1948,
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife J. Thomas Rue 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 28 1869
(Month) (Day) (Year)

Immediate cause of death myocardial failure
Due to mitral Stenosis
Due to _____
Other conditions fractured hip
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
79 7 27 hr. min.

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED
Underline the cause to which death should be charged statistically.

9. Birthplace Wagler county Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business At Home

12. Name Andrew Baker

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

14. Maiden name Martha Blankenship

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

16. (a) Informant Mrs Charles A. Robinson

(b) Address Monroe Mo.

17. (a) Burial (b) Date thereof 9/27/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion, Cuba

18. (a) Signature of funeral director Palmer

(b) Address Lebanon Mo.

19. (a) 9-28-48 (b) Thosias B. Lyonly
(Date received local registrar) (Registrar's signature)

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)
Means of injury _____

23. Signature James L. Hope (M. D. or other) _____
Address Lebanon, Mo. Date signed 9/27/48

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.....

Emmett E. Eversett....., Registered Apprentice No. *246*
working under my personal supervision.

Signed *Richard L. Palmer*.....

Licensed Embalmer No. *4595*.....

P. O. Address *Lebanon, 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.

Registration District No. 170

Primary Registration District No. 5634

1. PLACE OF DEATH:

(a) County Laclede rural
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Arleena E Rue

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days _____
(if less than one day) _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 21-
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence July 1, 1948

(c) Where did injury occur? Laclede, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
farm

While at work? _____ (Specify type of place)

23. Signature James S. Hoopes (M. D. or other) fall
Sebanon, Mo

Date signed 10/20/48

SUPPLEMENTARY

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

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