

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

39297

1929

1. PLACE OF DEATH

County Madison Registration District No. 16 File No. _____
 Township Pacheco Primary Registration District No. 5020 Registered No. 9
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

George Littleberry Laffoon

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Laffoon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 | 7 | 16 | _____

8. OCCUPATION OF DECEASED Retired Farmer
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Indy.

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Skirley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown

14. INFORMANT Sollie Trotter
 (Address) Union Star

15. FILED Dec 18, 1928 Miss. Bettie Boyers
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 17 1928

17. I HEREBY CERTIFY That I attended deceased from April 1st, 1926, to May 1st, 1927, that I last saw him alive on May 1st, 1927, and that death occurred, on the date stated above, at 7:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Inf. D. Hemiplegia

CONTRIBUTORY (SECONDARY) None
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? None DATE OF _____
 WAS THERE AN AUTOPSY? None

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) A. O. Barnes, M. D.
Dec 17, 1928 (Address) Union Star Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Star Cemetery DATE OF BURIAL 12/19 1928

20. UNDERTAKER H. Hill Wilson ADDRESS King City Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

