

REC'D FEB 21 1939

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

Do not use this space.

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.

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1. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township St. Joseph Mo. Primary Registration District No. 1201 File No. 1667  
 City St. Joseph Mo. St. St. Joseph Mo. Registered No. 65 Ward 1  
 2. FULL NAME Margaret (Carmel) Laffoon  
 (a) Residence, No. 1201 Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 5 - 1938  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
9 16  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union Star Mo.  
 MOTHER  
 13. NAME Clyde Laffoon  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union Star Mo.  
 15. MAIDEN NAME Wileen Feckler  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union Star Mo.  
 17. INFORMANT Wileen Laffoon  
 (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Union Star Mo. DATE 1-23-39  
 19. UNDERTAKER R. J. Haggart  
 (ADDRESS) Kingfield Mo.  
 20. FILED Jan. 23 1939 W. H. Northrup Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-21-1939  
 22. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1939, to Jan 21, 1939  
 I last saw her alive on Jan 21, 1939 Death is said to have occurred on the date stated above, at 1:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Pneumonia, lobar primary  
 Date of onset 1-10-39  
 Other contributory causes of importance:  
otitis media, acute bilateral  
 Name of operation Paracentesis-Ears Date of 1-11-39  
 What test confirmed diagnosis? Clinical Was there an autopsy? No.  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No.  
 If so, specify \_\_\_\_\_  
 (Signed) W. Roan Moore M. D.  
 (Address) St. Joseph, Mo.

R. G. Taggart No. 25