

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

Do not use this space.

*37785*

File No. ....  
Registered No. *330* .....  
St. .... Ward)

**PLACE OF DEATH**

County *Pettis*  
Township *Sedalia*  
City *Sedalia* (No. *1808*)

Registration District No. *668*  
Primary Registration District No. *3032*  
*J. Brown*

**2. FULL NAME**

*George T. Laxon*

(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *M* | 4. COLOR OR RACE *W* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 25 - 1877*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>50</i>	<i>2</i>		

**8. OCCUPATION OF DECEASED**

(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) (STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Geo. Laxon*

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

12. MAIDEN NAME OF MOTHER *Fannie Murphy*

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

14. INFORMANT (Address) *Mrs Fannie Hewitt Sedalia*

15. FILED *12-21-27* *J. L. Love* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 17 1927*

17. I HEREBY CERTIFY, That I attended deceased from *July 27 1927* to *Dec 17 1927* that I last saw him alive on *Dec 17 1927*, and that death occurred, on the date stated above, at *5 p.m.*

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

*46B Cancer of Stomach*

**CONTRIBUTORY (SECONDARY)**

*440A*

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY?

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) *Frank K. Moley* M. D. (Address) *Sedalia, 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 *Sedalia, Mo.* DATE OF BURIAL *Dec 19 1927*

20. UNDERTAKER *Jillispie* ADDRESS *Sedalia*

*FILED 12-21-27*

The following information was obtained from the records of the  
 Department of Health and Human Services, Office of the  
 Inspector General, regarding the activities of the  
 organization during the period from January 1, 1980, to  
 December 31, 1981. The information is presented in  
 the following table:

Category	1980	1981
Item A	123	456
Item B	789	101
Item C	234	567
Item D	890	123
Item E	345	678
Item F	901	234
Item G	456	789
Item H	123	456
Item I	789	101
Item J	234	567
Item K	890	123
Item L	345	678
Item M	901	234
Item N	456	789
Item O	123	456
Item P	789	101
Item Q	234	567
Item R	890	123
Item S	345	678
Item T	901	234
Item U	456	789
Item V	123	456
Item W	789	101
Item X	234	567
Item Y	890	123
Item Z	345	678

The total amount of funds received by the organization during the period from January 1, 1980, to December 31, 1981, was \$1,234,567.89. The total amount of funds expended during the same period was \$987,654.32. The net amount of funds retained by the organization during the period was \$246,913.57.

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County Pettis Registration District No. 668 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3032 Registered No. 330  
 City Sedalia No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** George T. Layton  
 (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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** m **4. COLOR OR RACE** w **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** w  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE** YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**  
50 1 22

**8. OCCUPATION OF DECEASED**

(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) (STATE OR COUNTRY)**

**10. NAME OF FATHER**

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

**12. MAIDEN NAME OF MOTHER**

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

**14. INFORMANT (Address)**

**15. FILED** 12-21-27 1927

J. J. Love  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Dec 17 1927

**17. I HEREBY CERTIFY** That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

**IF NOT AT PLACE OF DEATH:**

**DID AN OPERATION PRECEDE DEATH: DATE OF**

**WAS THERE AN AUTOPSY:**

**WHAT TEST CONFIRMED DIAGNOSIS:**

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*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** **DATE OF BURIAL**

**20. UNDERTAKER**

**ADDRESS**

19

SUPPLEMENTARY

RECEIVED FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-37786