

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

Do not use this space.

15565

1. PLACE OF DEATH
 County Cass Registration District No. 149
 Township Union Primary Registration District No. 2-13
 City (No.) St. Ward

2. FULL NAME Roma B Baffoon
 (a) Residence No. St. Ward

Length of residence in city or town where death occurred 19 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No.
 Registered No.
 St. Ward

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 30, 1880

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, — hrs. or — min.
	<u>49</u>	<u>6</u>	<u>21</u>	

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/21 1930

17. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19..... that I last saw h. alive on, 19....., and that death occurred, on the date stated above, at about 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental - Fell in well
183
196A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Newton Baffoon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Cyelia Maxwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

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

19. DID AN OPERATION PRECEDE DEATH?

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) W. Anthony S. Gilkerson, M.D.
 , 19 (Address) Cass

*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.

14. INFORMANT Mrs Delpha Dalton
 (Address) Cleveland, Mo.

15. FILED 5-23 1930 Geo. C. Myers
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Shelwood DATE OF BURIAL 5-23 1930

20. UNDERTAKER Remmerburger Bros ADDRESS Harrisonville 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.

JUN 24 1930

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Cass Registration District No. 149 File No. _____
 Township Union Primary Registration District No. 52-13 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Roma L. 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 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) M

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.

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date and above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental - fell in well - drownd.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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.

SUPPLEMENTARY

182

14. INFORMANT _____ (Address) _____

15. FILED 5/23 19 30 Geo. E. Myers REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

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. REGISTRARS SHALL NOT RECEIVE-A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1000