

APR 17 1939

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

9677  
Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. 4119 Terrace St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 245 John Chase Laughlin  
(a) Residence, No. 4119 Terrace St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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 Gertrude A. Laughlin  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1, 1864  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 11 22

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Bldg. Supt.  
9. Industry or business in which work was done, as saw mill, bank, etc. Ret. 10 yrs.  
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) Ohio

FATHER  
13. NAME David Laughlin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

MOTHER  
15. MAIDEN NAME Mathilda Wilson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

17. INFORMANT (ADDRESS) Mr. Davis Laughlin  
720 Parallel K.G.K.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE March 25, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gates Funeral Home  
Kansas City, Kansas

20. FILED 3-24-39 M. M. Crow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 11, 1939, to March 23, 1939.  
I last saw him alive on March 22, 1939. Death is said to have occurred on the date stated above, at 7:25 p.m.  
The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_  
Cardiac Asthma  
95 P  
Other contributory causes of importance:  
Senile Heart trouble

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) Dr. W. H. Kinsinger, M.D.  
4050 Broadway (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.

W. H. Niswonger

4050 Broadway

Until 5:30

---

---

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**