

REC'D MAY 18 1939

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

14792
Do not use this space.

1. PLACE OF DEATH

(a) County FRANKLIN Registration District No. 295
(b) Township..... Primary Registration District No. 4179 Registered No. 23
(c) City SULLIVAN (d) Street No. 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 2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

150 ALEXANDER LAFFOON
(a) Residence, No. SULLIVAN, MISSOURI 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 Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mamie Laffoon
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 24, 1852.
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 1 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired Farmer
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (CITY OR TOWN) Herculaneum 0
(STATE OR COUNTRY) Missouri

FATHER 13. NAME Alexander Laffoon 1

14. BIRTHPLACE (CITY OR TOWN) Kentucky 0
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Hettie Ellis

16. BIRTHPLACE (CITY OR TOWN) Jeff. Co.
(STATE OR COUNTRY) Missouri

17. INFORMANT Edgar W. Laffoon
(ADDRESS) Sullivan

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____

19. FUNERAL DIRECTOR Thos. P. Shaffer
(ADDRESS) Sullivan, Missouri.

20. FILED April 14 1939 Edgar W. Laffoon 993
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14 19 39
22. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1939, to April 14, 1939
Last saw him alive on April 13, 1939. Death is said to have occurred on the date stated above, at 8:30 a. m. M.
The principal cause of death and related causes of importance were as follows:

Pneumonia
Date of onset 11/2
Other contributory causes of importance: depression & etc.

Name of operation None Date of _____
What test confirmed diagnosis? Physical 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. P. Rose, M. D.
Sullivan, Missouri. 1

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 importu

STATEMENT BY LICENSED EMBALMER

I, THOS. P. SHAFFER, Licensed Embalmer No. 2692

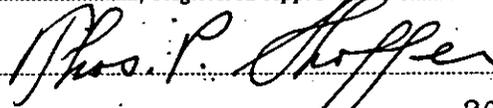
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me:

L. E.

No. 2692 or by Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 2692

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

14792
Do not use this space.

1. PLACE OF DEATH
 (a) County Franklin Registration District No. 295-
 (b) Township Primary Registration District No. 4179
 (c) City Sullivan (d) Street No. 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 Alexander Laffoon
 (a) Residence, No. 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>87</u>	MONTHS <u>1</u>	DAYS <u>20</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as 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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Hillsboro</u> DATE <u>4-16-1939</u>				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED <u>6/2</u> 19 <u>39</u> <u>@Wrauter</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-14-1939

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

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) R. P. Royce M. D.
 (Address) Sullivan Mo.

SUPPLEMENTARY

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 COMPLETED AS PRESCRIBED BY LAW.

