

Registration District No. **29**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2319 Oakley St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **20 Years**
years, months or days

3. (a) PRINT FULL NAME **Fred La Fountain**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **486-01-5608**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lila LaFountain** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **April 15 1895**
(Month) (Day) (Year)

8. AGE: Years **46** Months **11** Days **9** If less than one day
hr. min.

9. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Police Dept.**

11. Industry or business **Maintaince Dept.**

MOTHER FATHER { 12. Name **Alfred LaFountain**
13. Birthplace **Canada**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Lund**
15. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lila LaFountain**

(b) Address **2319 Oakley St.**

17. (a) **Burial** (b) Date thereof **3 / 27 / 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Rose & Henderson**

(b) Address **15th & Jackson St.**

19. (a) **3-27-42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2319 Oakley St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24**
year **1942** hour **1:20** minute **A.** M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *John B. Long*.....
Licensed Embalmer No. *9955*.....
P. O. Address *P. O. 9nd*.....

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, fact should be so stated above.