

FILED JUL 17 1943

Registration District No. _____

Primary Registration District No. 3063

Registrar's No. 1584

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

5926

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Saint Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin ³⁶

(c) City or town Sullivan ⁴
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elsie M. Laffoon

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 22 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>3</u>	<u>16</u>	hr. _____ min.

9. Birthplace Laffoon South Dakota
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Alex Laffoon

{ 13. Birthplace Herculeaneum Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Mamie P. Russell

{ 15. Birthplace Independence Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edgar Laffoon

(b) Address Sullivan, Missouri

17. (a) Burial (b) Date thereof 6/10/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willow Springs, Mo

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUL 12 1943 (b) E. J. McFarland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1943 hour 8:15 minute _____ P. M.

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

Immediate cause of death Natural causes.

Due to Cerebral hemorrhage.

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy Yes.

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 3

23. Signature Docie H. Rappaporter
(M. D. or other)

Address Kirkwood, Mo. Date signed 7-9-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

This body was not embalmed..... Registered Apprentice No.....
working under my personal supervision.

Signed..... *G. W. Wilkinson*

Licensed Embalmer No..... *3575*

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, fact should be so stated above.