

FILED JAN 6 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43415

State File No. _____

Registrar's No. 29

Registration District No. 280

Primary Registration District No. 4423

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Weston
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte
(c) City or town Weston
(d) Street No. _____
(e) Citizen of foreign country? no
If yes, name country _____

3. (a) PRINT FULL NAME James W. Layton

3. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Lydia Benner 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Aug. 27 1857
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 14
If less than one day hr. _____ min. _____

9. Birthplace Weston Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER

12. Name James H. Layton
13. Birthplace XX Kentucky
14. Maiden name Sally Smithers
15. Birthplace XX Kentucky

16. (a) Informant C. C. Layton

(b) Address Weston, Missouri

17. (a) Burial (b) Date thereof Dec. 14/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Bethel Cem.

18. (a) Signature of funeral director Vaughn Funeral Home

(b) Address Weston, Missouri

19. (a) 12-14-43 (b) Mrs. Clay Riffe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15 11
year 1943 hour 3 PM minute _____ M.

21. I hereby certify that I attended the deceased from September 24, 1943, to December 15, 1943, that I last saw im alive on December 15, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Glossolabio laryngeal paralysis (Bulbar palsy) Duration Six months

Due to Senile degeneration of centers and nerve filaments from bulb.

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

Major findings: Of operations no operation

Of autopsy no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) XXXXX
(b) Date of occurrence XXXXX
(c) Where did injury occur? XXXXX
(d) Did injury occur in or about home, on farm, in industrial place, in public place? XXXX

While at work XXXX (Specify type of place) (c) Means of injury XXXX

23. Signature Levis P. Cahery (M. D. or other) _____
Address Weston, Mo. Date signed Dec-13-43

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

1209

RECEIVED

District Health Officer No. Platts
District File Number 1-44-5
Date Filed 1-3-44

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 W. A. Vaughn
Licensed Embalmer No. 4023
P. O. Address Weston, Missouri

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.