V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 6 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34253

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 839

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 3 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 47
(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3
(d) Street No. 4226 Euclide Ave. (If rural, give location) 8
(e) Citizen of foreign country? (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Chester Lamb Laffoon
3. (b) If veteran, name war UNK.
3. (c) Social Security No. UNK.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Melody Laffoon
6. (c) Age of husband or wife if alive UNK years
7. Birth date of deceased June (Month) 27 (Day) 1911 (Year)

8. AGE: Years 33 Months 3 Days 25 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Sales and service manager
11. Industry or business
FATHER
12. Name Dr. Frances Laffoon
13. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)
MOTHER
14. Maiden name Ann Lamb
15. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Mrs Melody Laffoon
(b) Address 4226 Euclide Ave Kansas City Mo
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 23 (Month) (Day) 1944 (Year)
(c) Place: burial or cremation Newcomers
18. (a) Signature of funeral director Fred C. Thieme
(b) Address 1100 Boonville Ave., Spfd., Mo.
19. (a) 10-23-44 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22 year 1940 hour 6 minute 15 P M.
21. I hereby certify that I attended the deceased from Oct 21, 1944 to Oct 22, 1944; that I last saw him alive on 3 pm Oct 22, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fracture skull Basal and vault	36 hrs
Due to: Scalp wounds multiple	
Due to: Non-Collision	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

170C 28

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) Accident 106
(b) Date of occurrence Oct 20 1944 9:30 pm
(c) Where did injury occur? Taney County Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway accident - Public Place (Specify type of place)
While at work? No (e) Means of injury Car turned over
23. Signature Robert Glynn (M. D. or other) MD
Address Springfield, Mo. Date signed 10/23/44

(Licensed Embalmer's Statement on Reverse Side)

FEB 16 1945

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 Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, Mo

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.