

FILED JAN 14 1946 **STANDARD CERTIFICATE OF DEATH**

State File No.

Registration District No. 2

Primary Registration District No. 5013

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Rural #1, Monroe Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3 1/2 Miles East Cosby, /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Not
(Specify whether years, months or days)
 In this community 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Rural #1, Cosby
(If outside city or town limits, write "RURAL")
 (d) Street No. Rural
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Grant Ulyses Lafon

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 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 December 10 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 0 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____
 MOTHER FATHER { 12. Name William Lafon
 13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Lydia Sager
 15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Alise Swearingen
 (b) Address 916 No. 19th. St. St. Joseph, Missouri

17. (a) Burial (b) Date thereof 12/30/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cemetery

18. (a) Signature of funeral director Walter Meierhoffer
 (b) Address 1302 Faraon, St. Joseph, Missouri.

19. (a) 1-7-46 (b) William Sparks
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26th.
 year 1945 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from DEC. 26
1945, to DEC. 26 1945
 that I last saw him alive on DEC. 26 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration

Due to _____
 Due to _____
 Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings: Of operations _____
 Of 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) _____
 (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 W.B. Maxwell (M. D. or other) Dr.
 Address Cosby, Mo. Date signed 1/1/46

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

RECEIVED
District Health Officer No. 11,
District File Number.....
Date Filed.....

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 Albert R. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, 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.