

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1367**

FILED JAN 20 1955

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **1**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. CITY OR TOWN Independence	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 5 yrs.		e. STREET ADDRESS (If rural, give location) 323 N. Hocker	
d. FULL NAME OF HOSPITAL OR INSTITUTION 323 N. Hocker			

3. NAME OF DECEASED (Type or Print) a. (First) Julius Laspy b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) January 1, 1955		
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH December 8, 1908	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) Paper Handler	10b. KIND OF BUSINESS OR INDUSTRY K. C. Star	11. BIRTHPLACE (City and State or Foreign Country) Lawrence, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Julius Laspy	13b. MOTHER'S MAIDEN NAME Mary Franklin	14. NAME OF HUSBAND OR WIFE Elsie Mae Laspy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 514-05-8141	17. INFORMANT'S SIGNATURE OR NAME Agnes Taylor ADDRESS 521 N. Hocker
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot Fracture of Skull (Occipital Region)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Internal Cerebral Hemorrhage DUE TO (c) Shock.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Homicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 323 N. Hocker	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Independence Jackson MO.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 1, 1955 2:15 p.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? don't know
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Deputy Coroner (Degree or title) 3 M.A.	23b. ADDRESS 1618 Lydia Ave	23c. DATE SIGNED 1-7-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/8/55	24c. NAME OF CEMETERY OR CREMATORY Franklin Cemetery	24d. LOCATION (City, town, or county) (State) Muncie Kansas
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DATE REC'D BY LOCAL REG. 1-5-55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE C. E. David Funeral Home ADDRESS 1415 Sumner St.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

VS JUL 16 1952

FEB 10 1952

JAN 20 1952

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 Student Embalmer No. working under my personal supervision..

Student Signature of Student Embalmer

Signed *Landis H. Jackson*

Licensed Embalmer No. *4850*

P. O. Address *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.