

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-001230

FILED VS FEB 1 1960 133

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 14

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>HARRISON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>HARRISON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in lb <u>4 Days</u>		c. CITY OR TOWN <u>Eagleville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Noll Memorial Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>Sipple</u> Last <u>LAFFOON</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>26</u> , Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 6, 1895</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (City and state or country) <u>Gentry Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Anderson Z. Laffoon</u>			13b. MOTHER'S MAIDEN NAME <u>Nellie Ann Wilkerson</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA Bryout Laffoon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-22-9285</u>		17. INFORMANT Address <u>ANNA B. Laffoon, Eagleville, Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSTERIOR MYOCARDIAL INFARCT</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>years.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>9-13-59</u> to <u>1-26-60</u> and last saw him alive on <u>1-25-60</u> Death occurred at <u>3:15</u> A. M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Albert Tubke M.D.</u> Degree or title				22b. ADDRESS <u>Bethany, Mo</u>		22c. DATE SIGNED <u>1-27-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>JAN 28, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Eagleville, Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Gerald W. Boggs, Eagleville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>1-28-1960</u>	26. REGISTRAR'S SIGNATURE <u>Gella Maxey</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gerald W. Bogges

Licensed Embalmer No. 4762

P. O. Address Eagleville, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.