

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017896

FILED VS MAY 12 1968

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1400

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>	Length of stay in 1b <u>13 days</u>	c. CITY OR TOWN <u>St. Louis</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>Rob't Koch Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>2651 Chippewa</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Laffold</u> Last <u>Laffold</u>	4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>60</u>
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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>9-5-89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u> Hours <u>60</u>	IF UNDER 24 HR Min. <u>60</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Laffold</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Laffold</u>	14. NAME OF HUSBAND OR WIFE <u>Ethel Laffold</u>
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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>407-05-6663</u>	17. INFORMANT Address <u>Rob't. Koch Hospital Record Room Koch, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u> DUE TO (b) <u>Chronic Alcoholism</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 months</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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 4-15-60 to 4-28-60 and last saw ^{her}_{him} alive on 4-28-60
Death occurred at 9:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Axel R. Lironan, M.D.</u>	22b. ADDRESS <u>Robert Koch Hospital, Koch</u>	22c. DATE SIGNED <u>4-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>	23d. LOCATION (City, town, or county) (State) <u>POND Mo.</u>
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24. FUNERAL DIRECTOR <u>SCHRADER</u>	ADDRESS <u>BALLWIN, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-29-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.