

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023255

FILED VS JUN 30 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3108 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>16 years</u>	c. CITY OR TOWN <u>Kansas City</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>Osteopathic Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1633 Fremont</u>

3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Laffoon</u> Last <u>Laffoon</u>	4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1960</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>10-15-1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>71</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>	11. BIRTHPLACE (City and state or country) <u>Kearney Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James M. Laffoon</u>	13b. MOTHER'S MAIDEN NAME <u>Lina Randall</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Laffoon</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>None</u>	17. INFORMANT <u>Helen Laffoon</u>	Address <u>1633 Fremont</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>		<u>Instant.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypostatic pneumonia</u>	<u>2 days</u>
	DUE TO (c) <u>Peritonitis</u>	<u>7 days.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Sigmoid Polypsis</u>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>1:30 p.</u> Month, Day, Year <u>June 1, 1960</u>	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 <u>Kansas City</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>June 1, 1960</u> to <u>6-9-60</u> and last saw him alive on <u>6-9-60</u> Death occurred at <u>1:30 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>M.C. Coakley D.O.</u> (Degree of title)	22b. ADDRESS <u>6735 Truman Rd</u>	22c. DATE SIGNED <u>6-10-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City, town, or county) <u>Kansas City Mo</u>	(State)
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24. FUNERAL DIRECTOR <u>Muehlebach</u>	ADDRESS <u>6800 Troost</u>	25. DATE RECD. BY LOCAL REG. <u>6-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. C. COAKLEY

**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 J. T. Crowell

Licensed Embalmer No. 490

P.O. Address K. E. Mo

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