

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016107  
STATE FILE NUMBER

AMENDED FILED MAY 1 1961  
Registration District No. 324 Primary Registration District No. 3092 Registrar's No. 66

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ BY AFFIDAVIT OF

DOCUMENT MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>16 hours</b>	c. CITY OR TOWN <b>Slater</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>845 N. Broadway</b>
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>EMMARILLAS</b> Last <b>LAFFOON</b>			4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/28/1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Potato Chip</b>	9. AGE (last birthday) <b>73</b>
11. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Fansler</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah J. Backus</b>	14. NAME OF HUSBAND OR WIFE <b>Harry Laffoon</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Oliver Laffoon, Slater, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Hemorrhages</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of Pancreas with</b>			<b>10 mo.</b>
DUE TO (c) <b>marked Abdominal metastasis</b>			
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 checked="" 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 <b>July 1958</b> to <b>April 26, 1961</b> and last saw her <b>her</b> alive on <b>April 25, 1961</b> Death occurred at <b>8:25 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C.A. McBurney, M.D.</b> (Degree or title)		22b. ADDRESS <b>Slater, Mo.</b>	22c. DATE SIGNED <b>4/26/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/28/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ridgepark</b>	23d. LOCATION (City, town, or county) (State) <b>Marshall, Mo.</b>
24. FUNERAL DIRECTOR <b>Haines Funeral Home, Slater, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-26-61</b>	26. REGISTRAR'S SIGNATURE <b>Carl G. Keal</b>

MAY 3 1961

NAME OF DECEASED \_\_\_\_\_

RESIDENCE OF DECEASED \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

SEX \_\_\_\_\_ RACE \_\_\_\_\_

AGE \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

PLACE OF INTERMENT \_\_\_\_\_

**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 Guy F. Hayes Jr.

Licensed Embalmer No. 4630

P. O. Address Slater, 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.