S. No. 2
OM—2-43
v. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1944

Registration District No. 59 — Primary Registration District No. 5232 — Registrar's No. 7

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Rural Union Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Cass
(c) City or town Rural Union Twp (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROBERT E. LAFFOON
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Amanda E. Laffoon
6. (c) Age of husband or wife if alive 14 years
7. Birth date of deceased Dec. (Month) 14 (Day) 1868 (Year)
8. AGE: Years 76 Months 2 Days 14 If less than one day hr. min.
9. Birthplace Cass (City, town, or county) Mo. U (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name John E. Laffoon
13. Birthplace Cleveland (City, town, or county) Mo. Va. U (State or foreign country)
14. Maiden name Rosa M. Powell
15. Birthplace Tenn. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Ina Collins
(b) Address Webb City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Cleveland Mo
18. (a) Signature of funeral director Geo E. Myers
(b) Address Cleveland Mo
19. (a) Dec 29-44 (Date received by registrar) (b) Margarett Polley Deputy Geo E Myers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Decmb day 28th year 1944 hour 10 minute — P. M.
21. I hereby certify that I attended the deceased from December 1, 1944, to December 26, 1944, that I last saw him alive on December 26, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Congested Heart failure	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Marion V Robbins (M. D. or other) MD
Address Rockar Mo Date signed 12/29/44

1047 (Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Geo. E. Myers

Licensed Embalmer No. 2517

P. O. Address Cleveland 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 this body is not embalmed, fact should be so stated above.