No. 2
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X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

William Oscar Vaughan

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16764

Registration District No. FILED JUN 10 1942

Primary Registration District No.

Registrar's No. 4529

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Lukes Hospital O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 DAYS (Specify whether

In this community 8 DAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Illinois (b) County NR

(c) City or town Fairfield (If outside city or town limits, write "RURAL")

(d) Street No. RFD #5 (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME William Oscar Vaughn

3. (b) If veteran, name war ?

3. (c) Social Security No. 357-01-5134 None

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced 2 Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec (Month) 16 (Day) 1874 (Year)

8. AGE: Years 67 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Wayne County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Wm J Vaughn
13. Birthplace (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Lucy Gray
15. Birthplace Wayne County (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Ann L Anderson

(b) Address Fairfield Ill

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-25-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Fairfield Ill

18. (a) Signature of funeral director Haeffle-Dixon

(b) Address Fairfield Ill

19. (a) MAY 25 1942 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 23 year 1942 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from MAY 15 1942 to MAY 23 1942 that I last saw him alive on MAY 23 1942 and that death occurred on the date and hour stated above.

Immediate cause of death BRAIN TUMOR non-malignant

Due to 7 56 d

Due to 54

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations BRAIN TUMOR

Of autopsy

Duration

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 Dr Frank E Henry (M. D. or other) MD

Address St Lukes Hospital Date signed May 23 1942

844 (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 Wm Herons, Registered Apprentice No. 306 working under my personal supervision.

Signed John Ketter

Licensed Embalmer No. 3880

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
0M—8-21-41
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DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No. 16764

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 4529

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

1. PLACE OF DEATH:

(a) County .....

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Luke's Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community 8 days

3. (a) PRINT FULL NAME William O. Vaughn

3. (b) If veteran, name war .....

3. (c) Social Security No. 557-01-5134

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Dec (Month) 16 (Day) 1874 (Year)

8. AGE: Years 67 Months 5 Days ..... If less than one day hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name .....

13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER 14. Maiden name .....

15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) JUL 17 1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Del. (b) County .....

(c) City or town Fairfield (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23 year 1942 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

S-16764