

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
472 W Morgan  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether  
In this community 48 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 97  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. 472 W Morgan  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME STELLA MAY VAUGHT

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife George W. Vaught 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 18 1877  
(Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Orrin Harvington

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

14. Maiden name Unknown

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

16. (a) Informant Clifford Vaught

(b) Address 472 W Morgan Marshall

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 44  
(Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cemetery Marshall Mo

18. (a) Signature of funeral director Harry Herabarger

(b) Address Marshall Mo

19. (a) 1-26-1944 (Date received local registrar) (b) Mrs. O. Weelbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year 1944 hour 8:55 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 1943, to Jan 25 1944  
that I last saw her alive on Jan 23 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial insufficiency Duration 7

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. C. Putnam (M. D. or other) \_\_\_\_\_

Address Marshall Mo Date signed 1-26

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

1213

RECEIVED

District Health Officer No. 8,

File Number

2-9-44

7781

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

*Harry Hershberger*

Licensed Embalmer No. *4357*

P. O. Address *Marshall 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.