S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 21 1945

Registration District No. 316

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6075

State File No. 7050

Registrar's No. 279

1. PLACE OF DEATH:

(a) County St. Francois

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

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

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

(d) Street No. 0
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME JOHN VAUGHAN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 11 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
69	6	9	hr. min.

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

10. Usual occupation Common labor

11. Industry or business

FATHER 12. Name Thomas Vaughan

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

MOTHER 14. Maiden name Mary B. Merritt

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (Month) (Day) (Year)

(c) Place: burial or cremation Irondale, Missouri

18. (a) Signature of funeral director C. Z. Boyer

(b) Address Desloge, Missouri

19. (a) 1-31-45 (Date received local registrar) Forrest Holman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 20 year 1945 hour 6 minute 10 P. M.

21. I hereby certify that I attended the deceased from December 30, 1944 to January 20, 1945; that I last saw him alive on January 20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Terminal uremia	Duration
Due to ADDITIONAL	
Due to SUPPLEMENTARY	
INFORMATION	
Other conditions REQUESTED (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 [illegible] (M. D. or other)

Address [illegible] Date signed 1-26-45

1379 (Licensed Embalmer's Statement on Reverse Side) Farmington, Mo.

RECEIVED

District Health Officer No. 4

District File Number 245-281

Date Filed 2-20-45

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 C. G. Bogler.

Licensed Embalmer No. 1671

P. O. Address Desloge, 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.

S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 279

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Rural St Francois 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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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

3. (a) PRINT FULL NAME John Vaughan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 11 (Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 20 year 1944 hour minute 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 Chronic nephritis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy 131 b

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

7050