

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
I X36671

STANDARD CERTIFICATE OF DEATH

State File No. 26228  
Registrar's No. 2139

Registration District No. 318 Primary Registration District No. 1003

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:  
5077 Washington Blvd 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 45 year (Specify whether years, months or days)

3. (a) PRINT FULL NAME FANNIE HELEN VAUGHN

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

4. Sex. F 5. Color or race. W 6. (a) Single, widowed, married, divorced. Widowed

6. (b) Name of husband or wife. Charles H. 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased. March 16 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 27 If less than one day hr. min.

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

10. Usual occupation. None

11. Industry or business.

12. Name Charles Houghtaling

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

14. Maiden name FANNIE 9

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

16. (a) Informant Mrs. Marie S. Hoffmann

(b) Address 5007 Washington Blvd

17. (a) Cremation (b) Date thereof 8-15-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Valhalla Crematory

18. (a) Signature of funeral director Josephine - Top Funeral Home Inc

(b) Address 1911 Washington Blvd

19. (a) (Date received local registrar) AUG 14 1945 (b) J. F. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. 000  
(c) City or town. St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 5077 Washington Blvd (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13 year 1945 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from June 15 1945 to Aug 13th 1945 that I last saw her alive on Aug 9th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral hemorrhage Duration 2W

Due to Arteriosclerosis 43+

Due to Senile changes

Other conditions none 83a  
(Include pregnancy within 3 months of death)

Major findings: none made  
Of operations

Of autopsy none made

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? ( ) Means of injury ( )

Signature Joseph Davie (M. D. or other)

Address 1406 Kansas Blvd Date signed 8-14-45

Dr. J. J. Davis  
Funeral Bldg  
Ma 1276  
2 P.M.

**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 Paul A. Shanklin  
Licensed Embalmer No. 3472  
P. O. Address 1911 Washington St

**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.**