

S. No. 2  
M-5-43  
7-5-17-39  
P I X3667

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3228

FILED JAN 17 1947  
Registration District No. 318

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 37

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. Louis Childrens Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Marion 999  
(c) City or town Centralia 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 515 James St. N.R. 3  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN DUNCAN VAUGHN

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 Single

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 23 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 9 hr. min.

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

10. Usual occupation Infant

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

MOTHER FATHER { 12. Name John T. Vaughn

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

14. Maiden name John Mary Duncan

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

16. (a) Informant John T. Vaughn

(b) Address Centralia, Illinois

17. (a) Cremation (b) Date thereof 1/3/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhall Crematory

18. (a) Signature of funeral director Albert H. Hoppe, Inc.

(b) Address 4700 Washington Blvd.

19. (a) JAN 3 - 1947 (b) J. F. Bredek  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2nd  
year 1947 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12-28 1946 to 1-2 1947  
that I last saw him alive on 1-2 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Premotility  
Intra-cranial hemorrhage

Due to \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 159

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) \_\_\_\_\_  
(c) Means of injury D

23. Signature R. J. Storie (M. D. or other) \_\_\_\_\_  
Address 1012 N. King Date signed \_\_\_\_\_

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

*No Embalmer*

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**