

S. No. 2  
-12-45  
5-17-39  
I X47070

FILED JUL 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21854

Registration District No. 276

Primary Registration District No. 4410

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St James  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Nancy J. Vaughan

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 wid

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

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

7. Birth date of deceased 2-23-1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>3</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation House wife

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

MOTHER FATHER

12. Name John Huffmann

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

14. Maiden name Katherine Reed

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

16. (a) Informant Thos. Johnson

(b) Address Kirkwood Mo

17. (a) Burial (b) Date thereof 6-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highgate Mo

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

(b) Address St James, Mo

19. (a) 7-6-47 (b) Para C. Birmingham  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

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

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

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19  
year 1947 hour 5:30 minute 0 M.

21. I hereby certify that I attended the deceased from June 12  
1947 to June 19, 1947  
that I last saw h. alive on June 18  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Emboli  
Chronic albuminuria

Due to 3 days

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

(e) Means of injury 0

23. Signature William Brewer (M. D. or other) \_\_\_\_\_

Address St James, Mo Date signed 6/20/47

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

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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 W. E. Licklider

Licensed Embalmer No. 1570

P. O. Address St James md

**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.**