

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1956

State File No. **3071**
Registrar's No. **78**

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	State File No. 3071		Registrar's No. 78	
1. PLACE OF DEATH a. COUNTY Mo. Pac. Employes Hospital, St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri. b. COUNTY City of St. Louis.			
b. CITY (If outside corporate limits, write RURAL and give township) City of St. Louis		c. LENGTH OF STAY (in the place) Nov. 16, 1955		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mp. Pac. Employes Hospital.				No. STREET ADDRESS (If rural, give location) 4203 Shenandoah Ave., 2179			
3. NAME OF DECEASED (Type or Print) a. (First) Mrs. Madeline M. Vaughan. b. (Middle) _____ c. (Last) Vaughan			4. DATE OF DEATH (Month) (Day) (Year) Jan. 3 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.	8. DATE OF BIRTH May 5, 1909.		9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Unemployed 1 1/2 Yrs.		11. BIRTHPLACE (City and State or Foreign Country) Grayville, Ill.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Fred Vaughan		13b. MOTHER'S MAIDEN NAME Della Mode		14. NAME OF HUSBAND OR WIFE Albert E. Vaughan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Albert E. Vaughan 4203 Shenandoah			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture Left Femur Adeno-Carcinoma of Sigmoid Colon ANTECEDENT CAUSES DUE TO (b) Generalized abdominal carcinomatosis <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> 1-4-56					INTERVAL BETWEEN ONSET AND DEATH 11-16-55 7-13-54 11-16-55	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Carcionma Sigmoid Colon 7-13-54					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about _____) Yes, St. Louis, Ill-16-55		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) City of St. Louis, Mo. 44 (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-16-55		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell on sidewalk after getting from auto.			
22. I hereby certify that I attended the deceased from Nov. 16, 1955 , to Jan. 3, 1956 , that I last saw the deceased alive on Jan. 3, 1956 , and that death occurred at 7:50A m. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Joseph A. Lembeck M.D.				23b. ADDRESS 1755 South Grand Blvs.		23c. DATE SIGNED Jan. 23, 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan. 5, 1956	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
DATE REC'D BY LOCAL REG. JAN 4 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			

Undertaker bring this certificate to him for his approval. J.A. Lembeck, M.D. WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William B. White*.....

Licensed Embalmer No. *429*

P. O. Address *4228 S. King*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.