

1-7-58

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1958

1477
STATE FILE NUMBER
167

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 167

300
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp.</u>		d. STREET ADDRESS <u>4829 Halley</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>M.</u> Last <u>Vaughan</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1894</u>		
9. AGE (In years lost birthday) <u>64-63</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trig. Representative Schroeder Trimmer</u>	11. BIRTHPLACE (City and state or country) <u>Lidney, Tex.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Maurice Vaughan</u>	13b. MOTHER'S MAIDEN NAME <u>Teresa Deabold</u>		
14. NAME OF HUSBAND OR WIFE <u>Hazel Vaughan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWI</u>	16. SOCIAL SECURITY NO. <u>326-07-0829</u>		
17. INFORMANT <u>Ms. Hazel Vaughan, 4829 Halley</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aneurysm</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>General arteriosclerosis + Pulmonary edema</u> DUE TO (c) <u>Previous myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>451X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>Five years terminal.</u> <u>?</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20f. CITY, TOWN, OR LOCATION		COUNTY STATE			
21. I attended the deceased from <u>1945</u> to <u>Jan. 10, 58</u> and last saw ^{him} alive on <u>Nov. 25, 1957</u> Death occurred at <u>4:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Lyle G. Willits M.D.</u> (Degree or title)			
22b. ADDRESS <u>1103 Grand Avenue</u>		22c. DATE SIGNED <u>Jan 11, 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-13-58</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>			
24. FUNERAL DIRECTOR <u>Melody - McElroy - Lyle & F.H.</u>		25. DATE RECD. BY LOCAL REG. <u>1-11-58</u>			
26. REGISTRAR'S SIGNATURE <u>Leva Marshall</u>		27. REGISTRAR'S NAME <u>Leva Marshall</u>			

Lyle G. Willits USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

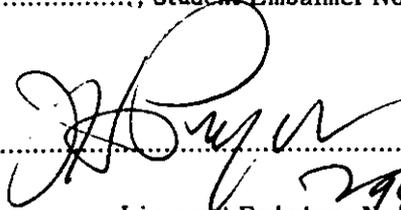
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

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