

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006305

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</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>116 East Clayton</u>		Length of stay in 1b <u>1 year</u>	d. STREET ADDRESS (If outside, give location) <u>116 East Clayton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Martiles</u> Middle <u>Vaughan</u> Last <u>Vaughan</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1870</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer (retired)</u>	11. BIRTHPLACE (City and state or country) <u>California, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>James William Vaughan</u>	13b. MOTHER'S MAIDEN NAME <u>Lillie Ann Birdsong</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie Vaughan (deceased)</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Gladys Winfrey, Brookfield, Missouri</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> Interval between onset and death <u>5 yrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> <u>10 yrs.</u> DUE TO (c) <u>Hypertension</u> <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>446X</u>		

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.)
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20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Brookfield, Missouri</u>	COUNTY <u>Missouri</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>1957</u> to <u>2/25/59</u> and last saw ^{her} him alive on <u>Feb. 25, 1959</u> Death occurred at <u>9 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>W B Simpson</u> (Degree or title) <u>Dr.</u>	22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>2/27/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>Hill Funeral Home</u> ADDRESS <u>Brookfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u> ^{dep}
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Gerald I Wade*

Licensed Embalmer No. *4172*

P. O. Address *Browning*

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.