

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022415

STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. 276

Primary Registration District No. 4410

Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <b>Phelps</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Phelps</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. James</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. James</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>None</b>			Length of stay in 1b		d. STREET ADDRESS <b>819 N. Evergreen</b> (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Andrew</b> Last <b>Vaughn</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1874</b>		9. AGE (In years last birthday) <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Vaughn</b>				14. MOTHER'S MAIDEN NAME <b>Emiline Roberts</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <b>Minvera Vaughn St. James, Missouri</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Stand Still</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Complete Heart block</b>						2 Months	
		DUE TO (c) <b>Arteriosclerotic Heart Disease</b> 4200						Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old Pectoris Coronary Dec 1958 &amp; H.S. Hypertension</b>								19. WAS AUTOPSY PERFORMED? <b>2</b> 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 <b>5:30</b> Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>Dec 1958</b> to <b>June 1959</b> and last saw <sup>not</sup> him alive on <b>June 12, 1959</b> . Death occurred at <b>5:30 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Samuel C. Boney, M.D.</b>				22b. ADDRESS <b>Sticker Clinic St. James Mo</b>				22c. DATE SIGNED <b>6/15/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>June 17, 1959</b>		<b>Roberts Cemetery</b>			<b>Crawford Co, Missouri</b>		
24. FUNERAL DIRECTOR <b>Jesse Gaber</b>				ADDRESS <b>2005. Ymerance St. James Mo</b>		25. DATE RECD. BY LOCAL REG. <b>June 15 1959</b>		26. REGISTRAR'S SIGNATURE <b>Ruth B. Powell</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
+790

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**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 *C. Jesse Gahr*.....

Licensed Embalmer No. *448*

P. O. Address *St. James*

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.