

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040545

FILED VS DEC 9 1959

146

Primary Registration District No. 3026

Registrar's No. 547

STATE FILE NUMBER

UNRECORDED

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If 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>Independence</u> | | Length of stay in lb <u>30 min</u> | | c. CITY OR TOWN <u>Blue Springs</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>Independence Hospital + Sanitarium</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>301 N. 15th St.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C</u> Last <u>Vaughn</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1959</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>Nov. 20, 1871</u> | | |
| 9. AGE (last birthday) <u>88</u> | | IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | |
| 11. BIRTHPLACE (City and state or country) <u>Jackson County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Silas Vaughn</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Robinson</u> | | |
| 14. NAME OF HUSBAND OR WIFE <u>Mamie Vaughn</u> | | 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>Mamie Vaughn</u> Address <u>301 N. 15th Blue Springs, Mo.</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>Acute cardiac failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>coronary occlusion</u> | | | | | | <u>2 hr.</u> | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 <u>2:45</u> a.m. <u>A</u> Month, Day, Year <u>3-29-48</u> | | 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 <u>3-29-48</u> to <u>12-1-59</u> and last saw <u>him</u> live on <u>12-1-59</u> Death occurred at <u>2:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Merrill R. Bay M.D.</u> | | | | 22b. ADDRESS <u>Blue Springs</u> | | 22c. DATE SIGNED <u>12-1-59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Dec 3 1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs Cem</u> | | 23d. LOCATION (City, town, or county) (State) <u>Blue Springs Mo</u> | | |
| 24. FUNERAL DIRECTOR <u>Webb Funeral Home</u> | | ADDRESS <u>Blue Springs, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-3-59</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 6 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed William Greer

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.