

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1317-62-004667  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

AMENDED

FILED FEB 7 1962

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2808 Marcus Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN None VAUGHN</b>			4. DATE OF DEATH Month Day Year <b>1 26 1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>UNK. 1896</b>	9. AGE (last birthday) <b>Abt. 65</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. Hosp.</b>		11. BIRTHPLACE (City and state or country) <b>St. Chas. Missouri</b>		
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>William Vaughn</b>	13b. MOTHER'S MAIDEN NAME <b>Hattie Abbott</b>		14. NAME OF HUSBAND OR WIFE <b>Widowed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Geraldine Armstrong 2808 Marcus</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>Pneumonia, Fracture distal end of right femur</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Due to (b) suffered when struck by car operated by one George Owens in the University of Clara + St. Louis about 6:45 PM on December 21<sup>st</sup> 1961 accident</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>See above</b>				
20c. TIME OF INJURY Hour a.m. p.m. <b>6:15 p.m.</b>	Month, Day, Year <b>12-26-61</b>					
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.) <b>66<sup>th</sup> Street</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		COUNTY	STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <b>7:45 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>Helen L. Taylor, Coroner</b>			22b. ADDRESS <b>1300 Clark Ave.</b>		22c. DATE SIGNED <b>1-30-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/31/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		
24. FUNERAL DIRECTOR <b>Chas. J. Gates 4107 Finney Ave.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 30 1962</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

**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. 4580

P. O. Address 4107 Finney Avenue

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.