

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011962

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 210 Primary Registration District No. _____ Registrar's No. 18

STATE FILE NUMBER

FILED MAR 21 1962

| | | |
|---------------------|--------------|--|
| VS 300 Rev. 4/59 | DATE AMENDED | |
| 1 <u>1650</u> | | |
| 2 <u>1400</u> | | |
| 3 | | |
| 4 <u>1</u> | | |
| 5 <u>2</u> | | |
| 6 | | |
| 7 <u>1</u> | | |
| 8 <u>0</u> | | |
| <u>9332X</u> | | |
| 10 | | |
| 11 | | |
| 12 <u>86-2</u> | | |
| 13 <u>1-0</u> | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MERCER</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GRUNDY</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Morgan Twp</u> Length of stay in 1b <u>4 MONTH</u> | | c. CITY OR TOWN <u>Spickard</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>BOOTH NURSING HOME</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTELLA DOUGHERTY VAUGHN</u> | | | 4. DATE OF DEATH Month Day Year <u>MAR 13 1962</u> |
| 5. SEX <u>FEMALE</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>3-20-1877</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 9. AGE (last birthday) <u>84-11-23</u> |
| 11. BIRTHPLACE (City and state or country) <u>NEWCASTLE DELAWARE</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>JOHN DOUGHERTY</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rhoda Lowe</u> | 14. NAME OF HUSBAND OR WIFE <u>ARTHUR 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. _____ | |
| 17. INFORMANT <u>WILBUR VAUGHN Spickard MO.</u> | | Address _____ | |
| 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>Cerebral Thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> |
| DUE TO (b) _____ | | | |
| 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 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 a.m. p.m. Month, Day, Year | | | |
| 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>11-15-61</u> to _____ and last saw her alive on <u>3-8-62</u> | | Death occurred at <u>6:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) <u>Walter O. Pearson D.</u> | | 22b. ADDRESS <u>Princeton, Mo.</u> | 22c. DATE SIGNED <u>3-14-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>3-15-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>Spickard MO.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>WISE FUNERAL HOME Spickard MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-14-62</u> | 26. REGISTRAR'S SIGNATURE <u>Joe Mann</u> |

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard Mo.

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.