

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037946

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 473

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 7 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
0168						
21000						
3						
4 0						
5 0						
6						
7 0						
8 0						
9773.5						
10	SHOULD READ	ITEM NO.	BY AFFIDAVIT OF			
11						
121-2						
131-1						

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		c. CITY OR TOWN <u>VANDUSER</u>	
Length of stay in lb		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>CAPE OSTEOPATHIC HOSP</u>		d. STREET ADDRESS (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KEVIN</u> Middle <u>EUGENE</u> Last <u>VAUGHN</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/62</u>
9. AGE (last birthday)		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU, MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>ROGERS MURIEL VAUGHN</u>	
13b. MOTHER'S MAIDEN NAME <u>MARGARET M. LANCASTER</u>		14. NAME OF HUSBAND OR WIFE	
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>MRS. JOHN GRIFFIN</u>		Address <u>SCOTT CITY 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>Cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>40 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) <u>prematurity (weight 15oz)</u>			
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 _____ a.m. _____ p.m. _____	Month, Day, Year		
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	COUNTY STATE
21. I attended the deceased from <u>3 AM Oct 4, 1962</u> to <u>3:45 AM Oct 4, 1962</u> and last saw <u>her</u> him alive on <u>Oct 4, 1962</u> Death occurred at <u>3:45 A m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George W England DO.</u>		22b. ADDRESS <u>46 W Main Cape Girardeau</u>	22c. DATE SIGNED <u>10/26/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/4/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CITY</u>	23d. LOCATION (City, town, or county) <u>MORLEY MO.</u>
24. FUNERAL DIRECTOR <u>EARL J. SMITH F. H.</u>		ADDRESS <u>ORAN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-1-1962</u>
		26. REGISTRAR'S SIGNATURE <u>James Kasten</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 Earl J. Smith

Licensed Embalmer No. 3676

P. O. Address Oren 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.