

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
WA 218951
 File No. _____
 Registered No. *18* _____

JUN 27 1929

1. PLACE OF DEATH

County *Polk* Registration District No. *601*
 Township *Little Prairie* Primary Registration District No. *3862*
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence *E. Paul Vaughn* St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Oscar Vaughn*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-24-1903*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<i>25</i>	<i>11</i>	<i>27</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *H. M.*
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Braggadocio*
 (STATE OR COUNTRY) *MO*

10. NAME OF FATHER *Bob Hamlet*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Tenn.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Emma Buller*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *KY*
 (STATE OR COUNTRY)

14. INFORMANT *Oscar Vaughn*
 (Address) *Braggadocio MO*

15. FILED *June 10 29* *Ada Martin*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-21 1929*

17. I HEREBY CERTIFY, That I attended deceased from *May 18*, 19*29*, to *May 21*, 19*29*, that I last saw her alive on *May 20*, 19*29*, and that death occurred, on the date stated above, at *3 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Puerperal Septicemia
140 (Secondary to abortion)
127 B (duration) _____ yrs. _____ mos. *4* ds.
36 *Cholecystitis*
 CONTRIBUTORY (SECONDARY) (duration) _____ yrs. _____ mos. *2* ds.

18. WHERE WAS DISEASE CONTRACTED *140*
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *no.* DATE OF _____

WAS THERE AN AUTOPSY? *no.*

WHAT TEST CONFIRMED DIAGNOSIS? *Cholecystitis*
 (Signed) *James F. Vickrey* M. D.

(Address) *Braggadocio MO*

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Culp Cemetery* DATE OF BURIAL *5-22 1929*

20. UNDERTAKER *H. S. Smith* ADDRESS *Wells MO*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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