

Do not use this space.

26433

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

SEP 24 1930

1. PLACE OF DEATH

County *Frank*
Township *Springfield*
City *Springfield*

Registration District No. *318*
Primary Registration District No. *218*
(No. *Spring District Hospital*)

File No. _____
Registered No. *643*
St. _____ Ward _____

2. FULL NAME

(a) Residence No. *Mrs. Harry Vaughan* St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Harry Vaughan*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 26 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 8 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

10. NAME OF FATHER *St. Talbot*

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

12. MAIDEN NAME OF MOTHER *Mary Kathleen*

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

14. INFORMANT (Address) *Harry Vaughan*
Mansfield Ave.

15. FILED *8/24 1930* Registrar *Gov. Sharp*

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-23-30*

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to *8-23-30*, 19____, that I last saw him alive on *8-23-30*, 19____, and that death occurred, on the date stated above, at *11:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Pneumonia resulting from
pharyngitis (duration) yrs. *5* mos. *5* ds.

CONTRIBUTORY (SECONDARY) *paronychia* (duration) yrs. *1* mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED *Blue Springs, Mo.*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *D. Roseberry*, M. D.
1/24 1930 (Address) *Springfield, Mo.*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mt. Vernon Ill* DATE OF BURIAL *8-25-30*

20. UNDERTAKER *W. H. Hersh* ADDRESS *Springfield, 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.

