

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

Do not use this space.

1. PLACE OF DEATH

County Scottland Registration District No. 810
Township Jefferson Primary Registration District No. 4488
City Memphis (No. 230) St. Ward

44804

File No.
Registered No. 49

2. FULL NAME

(a) Residence, No. St. Ward.

(Usual place of abode) (If nonresident, give city or town and State)
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 Male 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 Mary Vaughn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 18-1895

7. AGE YEARS 81 MONTHS DAYS 18 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Merchant

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scottland Co Mo

13. NAME R. J. Vaughn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pulaski Co Mo

15. MAIDEN NAME Isabell Lancaster

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pendleton Ky

17. INFORMANT (ADDRESS) R. L. Lancaster Memphis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Memphis DATE Nov 6 1939

19. UNDERTAKER (ADDRESS) W. H. V. Basket Memphis Mo

20. FILED Dec 7 1939 E. S. Farnish Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4 1939

22. I HEREBY CERTIFY, That I attended deceased from 7/23 1939 to 11/4 1939

I last saw alive on 11/4 Death is said to have occurred on the date stated above, at 10:45 P.M.

The principal cause of death and related causes of importance were as follows:

Coronary artery disease
3rd of 4th degree

Date of onset

Other contributory causes of importance: chronic nephritis

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) OTM Baker, M. D.

(Address) Memphis Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....,St.Ward)

2. FULL NAME

(a) Residence, No.....St.,Ward. (If nonresident, give city or town and State)
 (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE DATE 19.....				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19.....

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed)....., M. D.
 (Address).....

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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RECEIVED

District Health Officer No. 10

Registrar.

1-40-38