

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.

Registration District No. 266

Primary Registration District No. 4164

Registrar's No. 18

1. PLACE OF DEATH:
 (a) County Deot
 (b) City or town Salem, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 56. (Specify whether
 In this community years, months or days)

3. (a) PRINT FULL NAME James Madison Vaughn
 3. (b) If veteran, name war no. 3. (c) Social Security No. _____

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed.
 6. (b) Name of husband or wife Louise Grace Vaughn. 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 1 29 1852
 (Month) (Day) (Year)

8. AGE: Years 87 Months 0 Days 23 If less than one day hr. _____ min. _____

9. Birthplace Indiana Pitt. Wayne. (City, town, or county) (State or foreign country)

10. Usual occupation Labor.

11. Industry or business _____

MOTHER FATHER { 12. Name John Calvin Vaughn.
 13. Birthplace Don't know (City, town, or county) (State or foreign country)

{ 14. Maiden name Anna Couley.
 15. Birthplace Don't know. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mattie Wallof

(b) Address Salem, Mo.

17. (a) Burial (b) Date thereof 2 24-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker Cemetery

18. (a) Signature of funeral director Hobson & Braughton
 (b) Address Salem, Mo.

19. (a) February 23 1940 (b) F. Walter, M.D.
 (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Deot.
 (c) City or town Salem, Mo. (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month February day 22
 year 1940 hour 8 AM minute 9 M.
 21. I hereby certify that I attended the deceased from Feb 21
 _____, 1940, to Feb 22, 1940
 that I last saw _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration _____
High Leucemia
 Due to _____
 Due to _____
 Other conditions none
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy none
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury
 23. Signature St. J. Lillard (M. D. or other) M.D.
 Address Salem Mo Date signed Feb 22 1940

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.....

W. D. Holman

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

1 - File Number *340328*

Under No. *31240*

Signed *W. D. Holman*.....

Licensed Embalmer No. *929*.....

P. O. Address *Salem, 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 this body is not embalmed, above space should be left blank.