

25 1940

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

29913
Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 852
(b) Township Jackson Primary Registration District No. 6124
(c) City Boyer (d) Street No. _____ Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

George Washington Vaughn
(a) Residence, No. _____ (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 1, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 11 2

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

9. Industry or business in which work was done, as 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) Boyer Mo.

13. NAME James Vaughn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Mo.

15. MAIDEN NAME Liza Jane Sweet

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Mo.

17. INFORMANT (ADDRESS) Rosie Gentry Traylor

18. BURIAL, CREMATION, OR REMOVAL PLACE New Zion DATE 8-4 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Miller

20. FILED Aug 10 1940 Geo Hagan Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 3 1940

22. I HEREBY CERTIFY, That I attended deceased from 1935, 1935, to Aug 3, 1940

I last saw him alive on Aug - 2, 1940 Death is said to have occurred on the date stated above, at 2:00 p.m.

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

Arteriosclerosis - 1938
Chronic interstitial nephritis 1936

Other contributory causes of importance:
Chronic interstitial nephritis 1936

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1940

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? NO

If so, specify _____ (Signed) Geo Hagan

(Address) Miller Mo.

RECEIVED

District Health Officer No. 10

District File Number 9-40-1765

Date Filed SEP 10 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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 3792

P. O. Address Melan 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.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29913**

Registration District No. **852**

Primary Registration District No. **6124**

Registrar's No. _____

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Sullivan
 (c) City or town Baynton (Rural)
(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.

3. (a) PRINT FULL NAME Geo Washington Vaughan
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

20. DATE OF DEATH Month Aug day 3
 year 1940 hour _____ minute _____ M.

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

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

8. AGE: Years 81 Months 11 Days 2
 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace _____
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER
 { 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 { 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (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?
(Specify type of place)
 While at work? _____ (c) Means of injury _____

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) Oct 23/40 (b) Cleo Hagan
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTAL REPORT

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

