

FILED NOV 14 1942

State File No. \_\_\_\_\_

Registration District No. 387

Primary Registration District No. 6034

Registrar's No. 1865

1. PLACE OF DEATH:

(a) County Ripley  
 (b) City or town Rural Harris Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
4 miles S of Ripley  
(If not in hospital or institution, write street number or location)  
 (c) Name of hospital or institution:  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 14 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ripley  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
4 miles S of Ripley  
(If rural, give location)  
 (d) Street No. \_\_\_\_\_  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLAUDE FLOYD VAUGHN

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex male 5. Color or face white 6. (a) Single, widowed, married, divorced, married  
 6. (b) Name of husband or wife Nemie Vaughn 6. (c) Age of husband or wife if alive 41 years  
 7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51 7 26 hr. min.

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm Taylor Vaughn  
 13. Birthplace Calvin Miss.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Margaret Sam.  
 15. Birthplace Akin Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Nemie Vaughn  
 (b) Address Douglas Rt. 1, Mo.  
 17. (a) Rural (b) Date thereof Oct. 13-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation London Cem.  
 18. (a) Signature of funeral director Winnis Fish  
 (b) Address Naylor, Mo.  
 19. (a) 10/29/42 (b) E. B. Johnston  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11  
 year 1942 hour 8 minute 40 P.M.

21. I hereby certify that I attended the deceased from Oct 8, 1942, to Oct 11, 1942, that I last saw her alive on Oct 7, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death epilepsy  
hypertension  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions chronic  
(Include pregnancy within 3 months of death)

Duration

Major findings:  
 Of operations \_\_\_\_\_  
 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) \_\_\_\_\_  
 (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) (c) means of injury \_\_\_\_\_  
 23. Signature Stamulis (M.D. or other) \_\_\_\_\_  
 Address Naylor, Mo. Date signed 10/29/42

RECEIVED

District Health Officer No. 1

District File Number 11421002

Date Filed 11-13-42

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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

*S. C. McCord*

Licensed Embalmer No.

7979

P. O. Address

Naylor, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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4  
288

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 304642  
Registrar's No. 18601

Registration District No. 301

Primary Registration District No. 6034

1. PLACE OF DEATH:

(a) County Ripley  
(b) City or town Rural  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Claude F. Vaughn  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 3 17 1885  
(Month) (Day) (Year)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE: Years 51 Months 7 Days 10 If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
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)  
(b) 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1942

5-34642