

FILED OCT 7 1943 # 128

Registration District No. _____

Primary Registration District No. **2000**

Registrar's No. **800**

1. PLACE OF DEATH:

(a) County: **GREENE**
(b) City or town: **Springfield, Mo.**
(c) Name of hospital or institution: **773 W. Mt. Vernon**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community: **Life time.** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Greene** **039**
(c) City or town: **Springfield,** **2**
(If outside city or town limits, write "RURAL") **5**
(d) Street No.: **773 W. Mt. Vernon**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____ **11**

3. (a) PRINT FULL NAME

Grace Ellen Vaughan

3. (b) If veteran, name war _____

3. (c) Social Security No. **No**

4. Sex: **Female**

5. Color or race: **White**

6. (a) Single, widowed, married, divorced: **Married**

6. (b) Name of husband or wife: **Married Unk.**

6. (c) Age of husband or wife if alive: **57** years

7. Birth date of deceased: **Dec. 3, 1887**
(Month) (Day) (Year)

8. AGE: Years **55** Months **9** Days **25** If less than one day _____ hr. _____ min.

9. Birthplace: **Springfield, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation: **House wife**

11. Industry or business _____

12. Name: **David Marsh**

13. Birthplace: **Ind. Unk. Ind.**
(City, town, or county) (State or foreign country)

14. Maiden name: **Mary E. Connell**

15. Birthplace: **Springfield, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Maudie Fredrich,**
(b) Address: **763 W. Mt. Vernon, Springfield,**

17. (a) **Burial** (b) Date thereof: **Oct 2, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Maple Park**

18. (a) Signature of funeral director: **W. H. Dunn**
(b) Address: **629 W. Walnut Springfield, Mo.**

19. (a) **9-1-43** (b) **W. H. Dunn**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **28**
year **1943** hour **9** minute **10** A. M.

21. I hereby certify that I attended the deceased from **9-26-43**
_____ 19____ to **Sept. 28** 19____

that I last saw her alive on **Sept. 26** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Occlusion** Duration _____

Due to: **Arterio Sclerosis**

Due to _____

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

Major findings: **9/4**
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence: **No.**

(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: **E. J. ...**
Address: **432 Medical Arts Bldg.** Date signed: **9-30-**

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

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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 *Clarence D. M. Cook*

Licensed Embalmer No. *2891*

P. O. Address.....

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, fact should be so stated above.

X