

FILED MAY 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15861

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 959

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 24 days
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME James Vaughan
 3. (b) If veteran, name war --
 3. (c) Social Security No. --

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Belle Vaughan
 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased July 26, 1866
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	8	25	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Joseph W. Vaughan
 13. Birthplace Unknown Tenn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Anna C. Leach
 15. Birthplace Owensville Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L. Graham
 (b) Address 1827-Madison
 17. (a) Burial (b) Date thereof 4-24-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New Pickers

18. (a) Signature of funeral director General Funeral Home
 (b) Address 2233 Unive sity St.

19. (a) APR 22 1944 (b) E. B. McSavran M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Virgus
 (If outside city or town limits, write "RURAL")
 (d) Street No. Crave Coeur Lake
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4-20-44 day
 year 11:45 hour minute P. M.

21. I hereby certify that I attended the deceased from
3-27-44 19. to 4-20-44 19.
 that I last saw him alive on 4-20-44 19.
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 8 hrs.
 Due to Postoperative

Due to
 Other conditions Carcinoma of sigmoid colon 4-6 mos.?
 (Include pregnancy within 3 months of death)

Major findings: Carcinoma of colon removed by abdomino-peritoneal resection
 Of autopsy 4/6/44
 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) (e) Means of injury
 23. Signature John G. Wilson (M. D. or other) M.D.
 Address St. Louis County Hospital Date signed 4-22-44

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

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 *Edward R. Lockhart*

Licensed Embalmer No. *2502*

P. O. Address *Clayton 970*

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.