. S. No. 2
0M—2-43
v. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 24 1944

Registration District No. 7

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17577

Primary Registration District No. 1002

Registrar's No. 467

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1815 Felix
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1815 Felix
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James R. Vaughn
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 Alice E.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar (Month) 14 (Day) 1863 (Year)
8. AGE: Years 81 Months 1 Days 17 If less than one day hr. min.
9. Birthplace (City, town, or county) Ky (State or foreign country)
10. Usual occupation Retired Farmer 3 yrs
11. Industry or business
MOTHER FATHER
12. Name Stephen Vaughn
13. Birthplace (City, town, or county) Ky (State or foreign country)
14. Maiden name Martha
15. Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant Alice E Vaughn
(b) Address 1815 Felix
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Moro
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo
19. (a) 5/3/44 (Date received local registrar) (b) Rae Heizer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 year 1944 hour 11 minute 45 P.M.
21. I hereby certify that I attended the deceased from Mar 10/44, 19..., to May 1st, 1944, that I last saw him alive on 4/29/44, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia contrac	6 months
Due to: Senility and Malnutrition (chronic)	
Due to:	
Other conditions (include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work (e) Means of injury
23. Signature J H Hogsfoot MD (M. D. or other)
Address 825 Charles St. St Joseph Mo Date signed 5/1/44

1033 (Licensed Embalmer's Statement on Reverse Side)

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 Robert H. Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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, fact should be so stated above.