. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37273

State File No.

FILED NOV 20 1944

Registration District No. 1

Primary Registration District No. 1000

Registrar's No. 1137

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: St Joseph's Hosp n
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 40 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St Joseph 1
(If outside city or town limits, write "RURAL")

(d) Street No. 1815 Felix 7
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alice E. Vaughn

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James R

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

7. Birth date of deceased Oct (Month) 24 (Day) 1865 (Year)

8. AGE: Years 79 Months 0 Days 12 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ? Siers
13. Birthplace ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ?
15. Birthplace ? (City, town, or county) (State or foreign country)

16. (a) Informant P.R. Kirby
(b) Address St Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Mora Cem.

18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph, Mo.

19. (a) 11-8-44 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6
year 1944 hour 12 minute 01 P.M.

21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on Nov 6th, 1944 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 Self inflicted knife wound of Throat and abdomen — Duration 1 day

Due to Fatal Hemorrhage and Shock.

Due to 164d

Other conditions Woman inflicted a knife wound in her throat and one in her abdomen, ran out of the house went down on the street and ran into the side of an automobile receiving a minor head injury

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy No

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) Suicide

(b) Date of occurrence 11-5-44

(c) Where did injury occur? St Joseph (City or town) Buch (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In the Home (Specify type of place)

While at work? No (e) Means of injury knife

23. Signature H. F. Mundy 2 (M. D. or other) Coroner

Address 404 So 3d Date signed 11-6/44

1377

(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 L. 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.