V. S. No. 2
100M—5-43
Rev. 5-17-39
No. I X36671

#44729

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22690

FILED AUG 11 1945

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 6980

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17
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis (b) County 000
(c) City or town St. Louis 17 #19
(If outside city or town limits, write "RURAL")
(d) Street No. 702 N. Vandeventer Ave
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Michael Vaughn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M-2

5. Color or race Col

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 3 (Month) 9 (Day) 1945 (Year)

8. AGE: Years | Months 4 | Days 28 | If less than one day / hr. min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Robert Vaughn
13. Birthplace Hazelton (City or county) Mo (State or foreign country)
14. Maiden name Clay
15. Birthplace Kansas City (City, town, or county) Mo (State or foreign country)

16. (a) Informant Robert Vaughn
(b) Address 702 N. Vandeventer Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Cem—

18. (a) Signature of funeral director John N. Humphrey
(b) Address 408 S. Fillmore Ave Kirkwood

19. (a) AUG 8 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6th
year 1945 hour 9:10 minute P. M.

21. I hereby certify that I attended the deceased from 8/5/45, 19, to 8/6/45, 19;
that I last saw him alive on 8/6/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia

Due to Pertussis

Due to 9

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Samuel P. Bessman (M. D. or other) MD
Address 1515 Lafayette Date signed 8/7/45

(Licensed Embalmer's Statement on Reverse Side)

Bessman

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.....

.....myself....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....[illegible]

Licensed Embalmer No.....2266

P. O. Address.....2612, Thomas St.

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.