V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

State File No. 29446

FILED 0818 1945

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 8563

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-0-

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4102 Westminster 4 19
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John Luther Vaughn

3. (b) If veteran, name war None

3. (c) Social Security No. 499-12-3608

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Romi

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased April (Month) 13 (Day) 1897 (Year)

8. AGE: Years 48 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Creal Springs (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Barber

11. Industry or business

FATHER
12. Name William Lee Vaughn
13. Birthplace Metropolis (City, town, or county) Illinois (State or foreign country)

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

16. (a) Informant Mrs. Romi Vaughn
(b) Address 3866 Washington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 3 (Date received local registrar) (b) 1945 J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3rd
year 1945 hour 4 minute 30a M.

21. I hereby certify that I attended the deceased from
, 19, 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 Lobar Pneumonia

Due to

Due to 108

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 Patrick E. Taylor (M. D. or other)

Address Deputy Coroner Date signed 9-3-45

(Licensed Embalmer's Statement on Reverse Side)

NOV 16 1945

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 John Ogonoski

Licensed Embalmer No. 3398

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.