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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
FILED NOV 19 1945 STANDARD CERTIFICATE OF DEATH

State File No. **37260**

Registration District No. 129 Primary Registration District No. 5467 Registrar's No. _____

1. PLACE OF DEATH: Green
(a) County Green
(b) City or town Willard Robinson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. # 1
(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 Mo. (b) County Green 39
(c) City or town Willard 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. R.F.D. # 1
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AMANDA A. VAUGHN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased. Aug 93 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business at home

12. Name George Hall

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Vaughn

(b) Address R#6 Box 198 Springfield, MO

17. (a) Burial (b) Date thereof Nov 14 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brick Church Cem.

18. (a) Signature of funeral director W. Flugner & Co
(b) Address Springfield, Mo.

19. (a) Nov. 15, 1945 (b) Mrs. Herman White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1945 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from Nov 11
1945 to Nov 11 1945
that I last saw her alive on Nov 11 - 10 o'clock 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart Duration _____
acute

Due to Nephritis
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations NO
Of autopsy NO

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) NO

(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? no
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W F Kern (M. D. or other) 0

Address Springfield Date signed Nov 18

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

1203

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

County File Number 45-11-85

Date Filed 11-17-45

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.....

working under my personal supervision.

....., Registered Apprentice No.

Signed.....

Licensed Embalmer No. 4971

P. O. Address Springfield

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 129
Registrar's No. 5467

Registration District No. 129

Primary Registration District No. 5467

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural Roberson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Amanda A. Vaughn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Aug 23 1945
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) City or town _____ State _____ (b) County _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

that I last saw him _____ alive on _____, 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Chronic Bright disease

Due to only visit one time and she was ~~dead~~ at the time

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy 3/10

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 W. H. Kern (M. D. or other) _____
Address Springfield Date signed _____

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

SUPPLEMENTARY

37260