

FILED JAN 7 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1426

1. PLACE OF DEATH

(a) County Keye

(b) City or town St. Joseph

(c) Name of hospital or institution State Hospital # 2
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 15 yrs 4 mos 20 days
(If not in hospital or institution, write street number or location)

In this community 15 yrs 4 mos 20 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Nauvoo City
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson County Home
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Alma Vaughn

3. (b) If veteran, name war No

3. (c) Social Security No. Nil

4. Sex Female 5. Color or White

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

6. (b) Name of husband or wife Not given

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

7. Birth date of deceased December 6 1897
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21st
year 1946 hour 9 minute 2 A. M.

21. I hereby certify that I attended the deceased from Jan 1st 1946 to 12/21/46
that I last saw her alive on 12/21/46 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>0</u>	<u>15</u>	min.

Immediate cause of death Hypostatic pneumonia with emphysema

Due to Chorhea several years

Due to probably hereditary

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

10. Usual occupation Nil

11. Industry or business None

12. Name Not given

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

14. Maiden name Not given

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

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.

16. (a) Informant State Hospital # 2 records

(b) Address St. Joseph Mo.

17. (a) Reburial (b) Date thereof 12/27/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville Mo.

18. (a) Signature of funeral director Heaton Beale & Paulman

(b) Address St. Joseph, Mo.

19. (a) 12-31-46 (b) G. L. Jenkins
(Date received local registrar) (Registrar's signature)

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 G. L. Jenkins (M. D. or other) _____

Address State Hospital # 2 Date signed 12/21/46

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

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.....

Raymond W. Morehead

Licensed Embalmer No.....

441317

P. O. Address.....

319 S. 10th St. St. Joseph

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.