

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4655
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County *St. Louis*
(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. Marys Infirmary*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *43 days*
In this community *43 years*
years, months or days (Specify whether)

3. (a) PRINT FULL NAME *Ello Vaughn*
(b) If veteran, name war No. (c) Social Security No.

4. Sex *female* 5. Color or race *col* 6. (a) Single, widowed, married, divorced *single*

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

7. Birth date of deceased *6 2-1881*
(Month) (Day) (Year)

8. AGE: Years *63* Months *11* Days *1* If less than one day hr. min.

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

10. Usual occupation *housewife*

11. Industry or business

12. Name *Thomas Vaughn*

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

14. Maiden name *Liza Nelson*

15. Birthplace *St. Charles County, Mo.*
(City, town, or county) (State or foreign country)

16. (a) Informant *Edwan Vaughn*

(b) Address *3123 Pine St.*

17. (a) *Burial* (b) Date thereof *5-8-47*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Hopewell, Mo*

18. (a) Signature of funeral director *Bennie Love*

(b) Address *3103 Washington Ave*
(c) Date received local report *MAY 8 1947*

19. (a) *MAY 8 1947* (b) *J. B. Briscoe*
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State *MO* (b) County *St. Louis*
(c) City or town *St. Louis*
(If outside city or town limits, write "RURAL")
(d) Street No. *3123 Pine St.*
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* Day *3rd* Year *1947*
hour *1 o'clock* minute *0* M.

21. I hereby certify that I attended the deceased from *April 23* 19 *47* to *May 3* 19 *47*
and that death occurred on the date and hour stated above.

Immediate cause of death *Hypertensive Heart Disease*
Duration

Due to *9/8*

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 *D*

23. Signature *Franklin A. Love* (M. D. or other)

Address *1631 Fenwick Ave* Date signed *6/5/47*

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

MOTHER FATHER

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 *W. C. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alhine*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *may*Registration District No. *318*Primary Registration District No. *1003*Registrar's No. *465*

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:

(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 *Ella Vaughan*

3. (b) If veteran, name war.....
 3. (c) Social Security No. *5*

4. Sex *F* race *B* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *S*

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

7. Birth date of deceased.....
 (Month) *June* (Day) *2* (Year) *1947*

8. AGE: Years *63* Months *10* Days *10* If less than one day, hr. min.

9. Birthplace.....
 (City, town, or county) *St. Louis, Mo.* (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) *J. F. Bradack*
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (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 *1947* 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.....

Duration

- Due to.....

- Due to.....

- 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.

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)
 (c) Means of injury.....

23. Signature..... (M. D. or other)
 Address..... Date signed.....

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

STOP TEMPORARY 3

MOTHER FATHER

JUN 12 1947

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