

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

National Office of Vital Statistics

State File No. ....

FILED JAN 3 1949

Registration District No. ....

Primary Registration District No. 2807

Registrar's No. 297

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town SAVANNAH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Dr. Nichols Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution same (Specify whether years, months or days)  
In this community 2 weeks

3. (a) PRINT FULL NAME ONAMAY VAUGHAN

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

4. Sex Female 5. Color or race ..... 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Robert VAUGHAN 6. (c) Age of husband or wife if alive 5-0 years  
7. Birth date of deceased July 29 - 1898  
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 7 If less than one day hr. min.

9. Birthplace HILL CO., TEXAS  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business  
12. Name W. M. KEESEE  
13. Birthplace ARKANSAS  
(City, town, or county) (State or foreign country)  
14. Maiden name VIOLET PERKINS  
15. Birthplace TEXAS  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Nichols SANATORIUM  
(b) Address SAVANNAH MO

17. (a) Removal (b) Date thereof 12-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MANGUM OKLA

18. (a) Signature of funeral director E. C. Bree  
(b) Address Savannah Mo

19. (a) 12-24-48 (b) William Sparks  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State TEXAS (b) County 999  
(c) City or town LOCKNEY (If outside city or town limits, write "RURAL") 41  
(d) Street No. .... (If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No) 2  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20  
year 1948 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from Dec 10, 1948, to Dec 20, 1948,  
that I last saw her alive on Dec 20, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism  
chronic Subcarditis  
Due to .....  
Due to .....  
Other conditions (Include pregnancy within 3 months of death) .....

Duration

PHYSICIAN

Major findings: Of operations .....  
Of autopsy 92P

Underline the cause of 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 0  
23. Signature E. C. Bree (M. D. or other) .....  
Address Savannah Mo Date signed 12-20-48

DEC 30 1948

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address. Savannah

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.

Registration District No. 2 Primary Registration District No. 4009

1. PLACE OF DEATH:  
(a) County Andrew  
(b) City or town Sassaparilla  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Era May Vaughn  
3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased June 29 1888  
(Month) (Day) (Year)

8. AGE: Years 50 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-24-48 (b) Lillian Sparks  
(Date received local registrar) (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 Jan day 20  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her 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 \_\_\_\_\_

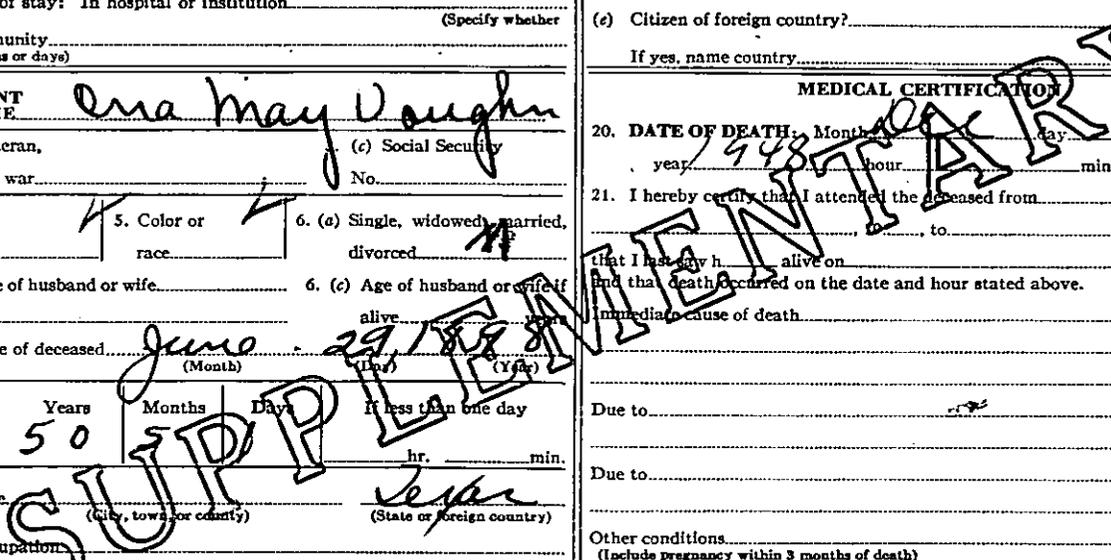
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_



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

MOTHER FATHER

39255