

THE DIVISION OF HEALTH OF MISSOURI
FILED AUG 14 1950 STANDARD CERTIFICATE OF DEATH

State File No. **25372**
6615

BIRTH NO. **115902-50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS 2109		
c. LENGTH OF STAY (In this place)			d. STREET ADDRESS (If rural, give location) 3047 A VINE GROVE		
d. FULL NAME OF HOSPITAL OR INSTITUTION SAINT LOUIS MATERNITY					

3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) c. (Last) VAUGHN			4. DATE OF DEATH (Month) (Day) (Year) JULY 25 1950		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JULY 25, 1950		9. AGE (In years last birthday) if UNDER 1 YEAR: Months Days if UNDER 2 HRS. Min. 9 150
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME MILFORD ALFONSO VAUGHN		13b. MOTHER'S MAIDEN NAME CHRISTINE ETTA GOODMAN		14. NAME OF HUSBAND OR WIFE SINGLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ST. LOUIS MATERNITY HOSPITAL	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity			ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
			DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS			Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? July 25 75/6X	
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22. I hereby certify that I attended the deceased from 3:40 a.m., 1950, to July 25, 1950, that I last saw the deceased alive on July 25, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. Ben Meritt, M.D.		23b. ADDRESS St. Louis Maternity Hosp		23c. DATE SIGNED July 25	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE AUG 3 1950		24c. NAME OF CEMETERY OR OPERATORY Anatomical Board	

DATE REC'D BY LOCAL REG. AUG 3 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Service - 4104 Manchester	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Merrett-

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 _____

....., Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

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.