

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

34233

State File No.

8308

BIRTH NO. _____ 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) | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS | | a. STATE Missouri b. COUNTY 2237 | |
| c. LENGTH OF STAY (in this place) 2 Wks. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL | | d. STREET ADDRESS (If rural, give location) 23 1714 South 13th. | |

| | | | | | |
|--|-------------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) MAY | b. (Middle) | c. (Last) VAUGHN | (Month) AUG. | (Day) 25 | (Year) 1953 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH 12-29-1895 | 9. AGE (In years last birthday) 57 | 10. IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Illinois. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | |
|--|---|------------------------------------|
| 13a. FATHER'S NAME Unk. | 13b. MOTHER'S MAIDEN NAME Unk. | 14. NAME OF HUSBAND OR WIFE |
|--|---|------------------------------------|

| | | |
|--|--------------------------------|---|
| 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. | 17. INFORMANT'S SIGNATURE OR NAME St. Louis, MO Margaret Grant, 2310a South Jefferson |
|--|--------------------------------|---|

| | | | |
|---|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF THE RECTUM | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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? 154X |

22. I hereby certify that I attended the deceased from JULY 12, 1953, to AUG. 25, 1953, that I last saw the deceased alive on AUG. 24, 1953, and that death occurred at 6:50 A. m., from the causes and on the date stated above.

| | | |
|--|---|--|
| 23a. SIGNATURE (Degree or title) Carl M. Janison M.D. | 23b. ADDRESS 4119 - FARLIN, ST. LOUIS, MO. | 23c. DATE SIGNED AUG 26, 1953 |
|--|---|--|

| | | | |
|--|--------------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 8-27-1953 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
|--|--------------------------------------|---|---|

| | | | |
|---|---|--|----------------|
| DATE REC'D BY LOCAL REG. AUG 27 1953 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin's, 2301 Lafayette, St. Louis, Mo. | ADDRESS |
|---|---|--|----------------|

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

0

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

James R. Supina
.....
Licensed Embalmer No. 4550
P. O. Address St. Louis, Mo

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.