

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. WAKEMAN
State File No. 26885

FILED AUG 23 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2002 Registrar's No. 784

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (In this place) 27 YRS	c. CITY OR TOWN SPRINGFIELD
d. FULL NAME OF HOSPITAL OR INSTITUTION 2027 NO. ROBBERSON		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) SARAH b. (Middle) ADELINE c. (Last) VAUGHAN		4. DATE OF DEATH (Month) (Day) (Year) AUG, 14, 1954	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT, 13, 1870
9. AGE (In years last birthday) 83		10. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (City and State or Foreign Country) GREENE COUNTY, IND.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME ALBERT BURCH	13b. MOTHER'S MAIDEN NAME MARTHA BURCH	14. NAME OF HUSBAND OR WIFE I. W. VAUGHAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME MISS RUTH VAUGHAN ADDRESS SPRINGFIELD, MO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction chronic		INTERVAL BETWEEN ONSET AND DEATH 1 year?
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Colon Ascending		
	DUE TO (c) Scurvy		
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 153 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from June, 1954, to Aug 14, 1954, that I last saw the deceased alive on Aug 12, 1954, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 8-16-54
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-16-54	24c. NAME OF CEMETERY OR CREMATORY EASTLAWN CEMETERY
		24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI

DATE REC'D BY LOCAL REG. 8-17-54	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE HERMAN LOHMEYER ADDRESS SPRINGFIELD, MO
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WRITE PLAINLY—USING 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 Student Embalmer No..... working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed..... *Lucretia T. Swadlow*

Licensed Embalmer No... *481*

P. O. Address..... *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.