

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40119

State File No. _____

FILED DEC 20 1955

BIRTH NO. _____		REG. DIST. NO. <u>104</u>		PRIMARY REG. DIST. NO. <u>4176</u>		Registrar's No. <u>32</u>	
1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Malden</u>		c. LENGTH OF STAY (in this place) <u>39 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Malden</u>		d. STREET ADDRESS (If rural, give location) <u>Allen Alley</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>At Residence</u>				d. STREET ADDRESS (If rural, give location) <u>Allen Alley</u>			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
<u>John</u>		<u>John</u>		<u>Vaughn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 7-1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>1867-5-13</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>87-6-24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Smith Vaughn</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>W</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or known) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lila Kincaid Malden Mo</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac De-compensation</u> (b) <u>Severe Arterio Sclerotic Heart disease</u> (c) <u>Chronic Arterio Sclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prostatic obstruction</u> DUE TO (c) <u>and Gastritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>20 yrs</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No.</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>8-27-1955</u> to <u>Dec 7, 1955</u> , that I last saw the deceased alive on <u>12-7-1955</u> and that death occurred at <u>4:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>S.E. Mitchell M.D.</u>				23b. ADDRESS <u>Malden Mo.</u>		23c. DATE SIGNED <u>12-9-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-9-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Malden Mo</u>	
DATE RECD BY LOCAL REG. <u>12-14-55</u>		REGISTRAR'S SIGNATURE <u>J. D. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas C Knight</u>		ADDRESS <u>Malden Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED BUNNING COUNTY HEALTH
DEPARTMENT 12-19-50
COUNTY FILE NUMBER 1255

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 Thomas C. Knight

Licensed Embalmer No. 2189

P. O. Address Malden, 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.