

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033057

STATE FILE NUMBER 4317

FILED OCT 1 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4317

S. 300  
1-57 0

|   |                           |   |  |   |  |
|---|---------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON  |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY Jackson |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN KANSAS CITY  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN KANSAS CITY  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION V A HOSPITAL   |                           | Length of stay in 1b<br>55 years  | d. STREET ADDRESS (If outside, give location)<br>3810 EAST 18th  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                             |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>ALLEN VAUGHN  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>September 8, 1958  |   |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>June 26, 1884  |   | 9. AGE (In years last birthday) 74<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired painter & decorator  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Ft. Scott, Kansas  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |
| 13a. FATHER'S NAME<br>Charles Vaughn  |                           | 13b. MOTHER'S MAIDEN NAME<br>Olive Oliver   |  | 14. NAME OF HUSBAND OR WIFE<br>Minnie                               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes WWT   |                           | 16. SOCIAL SECURITY NO.<br>495 05 3250  |  | 17. INFORMANT<br>Address<br>VA Hospital Official Records, K. C. Mo. |  |
| 18. CAUSE OF DEATH (Write only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarct, coronary thrombosis  |                           |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |                           |   |  |   | 4201   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                           |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                                 |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>p.m.  |                           |   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                           | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                           |  |
| 21. Attended the deceased from August 19, 1958 to September 8, 1958 and assisted in his death.<br>Death occurred at 7:10 a. m. on the date stated above; and to the best of my knowledge, from the causes stated. |                           |   |  |   |  |
| 22a. SIGNATURE<br>E. FOROUGH, M.D. E. Forough M.D.  |                           |   | 22b. ADDRESS<br>VA Hospital, Kansas City, Mo.  |   | 22c. DATE SIGNED<br>9-8-58   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                           | 23b. DATE<br>Sept. 10, 1958   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEMORIAL PARK CEMETERY   |   | 23d. LOCATION (City, town, or county) (State)<br>KANSAS CITY MISSOURI                                  |
| 24. FUNERAL DIRECTOR<br>D.W. NEWCOMER'S SONS, 13317 BRUSH CREEK ADDRESS KANSAS CITY, MO.  |                           |   | 25. DATE RECD. BY LOCAL REG.<br>9-9-58   |   | 26. REGISTRAR'S SIGNATURE<br>Beva Marshall   |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Write only statements in item 18. No symptoms will be listed.

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 *W. P. Tolson* .....  
Licensed Embalmer No. 44421 .....  
P. O. Address Kansas City .....

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.