

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014944

FILED VS. MAY 16 1960 28

Primary Registration District No. 2000 Registrar's No. 529-0

STATE FILE NUMBER

|   |   |   |   |  |   |   |
|---|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> |  |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>SPRINGFIELD</b>   |   | Length of stay in 1b<br><b>82 YRS.</b>  |   | c. CITY OR TOWN <b>SPRINGFIELD</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>BAPTIST HOSP.</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>728 S. JEFFERSON</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>LENA</b> Middle <b>VAUGHAN</b> Last <b>TAYLOR</b>  |   |   | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>4</b> Year <b>1960</b>  |  |   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>4/25/72</b>   | 9. AGE (last birthday)<br><b>88</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOME</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (City and state or country)<br><b>OZARK, MISSOURI</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |
| 13a. FATHER'S NAME<br><b>JAMES R. VAUGHAN</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>BARBARA A. WEAVER</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>JOHN A. TAYLOR (DEC.)</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.<br><b>NO</b>  |   | 17. INFORMANT<br>Address<br><b>DR. W.E. TAYLOR, SPRINGFIELD, MO.</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE AURICULAR FIBRILLATION</b>   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 HRS.</b>                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |   |   |   |  |   |   |
| DUE TO (b) <b>CARDIAC CONGESTIVE FAILURE</b>  |   |   |   |  |   | <b>7 MO.</b>  |
| DUE TO (c) <b>NON-UNITED FRACTURE, NECK RT. FEMUR</b>   |   |   |   |  |   | <b>7 MO.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>SLIPPED &amp; FELL UPON KITCHEN FLOOR</b> |   |   |
| 20c. TIME OF INJURY<br><b>2</b> Hour<br><b>59</b> p.m.  | Month, Day, Year<br><b>OCT. 16 59</b>   |   |   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>HOME</b>   |   | 20f. CITY, TOWN, OR LOCATION<br><b>SPRINGFIELD GREENE MISSOURI</b>   |   |   |
| 21. I attended the deceased from <b>OCT. 16 1959</b> to <b>MAY 4 1960</b> and last saw her alive on <b>MAY 4 1960</b><br>Death occurred at <b>11:17 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |  |   |   |
| 22a. SIGNATURE<br><i>W. E. Taylor</i> (Degree or title)<br><b>M.D.</b>  |   |   | 22b. ADDRESS<br><b>SPRINGFIELD, MO.</b>   |  |   | 22c. DATE SIGNED<br><b>5/5/60</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>5/7/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAZELWOOD</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>SPRINGFIELD, MO.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>H. H. LOHMEYER, SPRINGFIELD, MO.</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-9-60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Effie S. Melton</i>   |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *M. L. M. O. O'Brien*

Licensed Embalmer No. 2727

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.