

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022460

FILED VS JUN 20 1960

43 Primary Registration District No. 3007 Registrar's No. 327

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Length of stay in 1b <b>3 days</b>		c. CITY OR TOWN <b>Campbell</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>W. Martin</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>FLORENCE</b> Last <b>VAUGHN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 13, 1873</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Booneville, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>unknown</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Hiram F. Vaughn</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>492-16-5862</b>		17. INFORMANT Address <b>Edward Garrison, Campbell, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterial embolus, left femoral artery</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? 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.)						
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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. I attended the deceased from <b>5-31-60</b> to <b>6-2-60</b> and last saw her live on <b>6-2-60</b> Death occurred at <b>6:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Robert W. Landess</i> (Deceased or title)				22b. ADDRESS <b>Poplar Bluff, Mo</b>		22c. DATE SIGNED <b>6-6-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 4, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Campbell Missouri</b>				
24. FUNERAL DIRECTOR <b>Landess Funeral Home, Campbell, Mo.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>6/10/60</b>	26. REGISTRAR'S SIGNATURE <i>R. W. Landess</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0531 8 8 NOV SA

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P.O. Address \_\_\_\_\_

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.