

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043729

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1359

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JAN 15 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1702 Savannah Ave.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 422 1/2 So. 6th St.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First LILLIAN Middle WISE Last VAUGHN			4. DATE OF DEATH Month December Day 28 Year 1961			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/26/1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Oscar Carter	13b. MOTHER'S MAIDEN NAME Anna (Unknown)	14. NAME OF HUSBAND OR WIFE Mr. Roy Vaughn
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Roy Vaughn	Address 422 1/2 So. 6th St St. Joseph Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Hemorrhage		2 days
DUE TO (b) _____		
DUE TO (c) _____		

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____
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21. I attended the deceased from 12/27/61 to 12/28/61 and last saw her alive on 12/27/61 Death occurred at 8:30P on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE D. E. Sklenar M.D.	22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo	22c. DATE SIGNED 12/29/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-15-62	23c. NAME OF CEMETERY OR CREMATORY Auburn Mt. Mora Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
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24. FUNERAL DIRECTOR Stacey Funeral Home	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Jan. 9, 1962	26. REGISTRAR'S SIGNATURE Wm. Clark Woodell
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DATE AMENDED: 1/29/62
INSTEAD OF: Blank & Mt. Mara
BY AFFIDAVIT OF Funeral Director: D.E. Sklenar, M.D.
ITEM NO.: 23b, c
SHOULD READ: 1/15/62 & Mt. Auburn

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph PA

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.