

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004188

FILED VS. JAN 22 1960

Registration District No.

Primary Registration District No.

Registrar's No.

2 493

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5161 Cabanne		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5161 Cabanne	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katie C. Vaughn		4. DATE OF DEATH Month 1 Day 11 Year 60			
5. SEX F	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-17-95	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Mansfield, La.	
13a. FATHER'S NAME William Canaan		13b. MOTHER'S MAIDEN NAME Malinda Jones		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT Sam Canaan-4345 Cook Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO (b) <u>450.0</u> DUE TO (c) <u>450.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus, Decubiti</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>o</u>			
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 Berkeley, Mo.		COUNTY STATE	
21. I attended the deceased from <u>Sept. 1959</u> to <u>Jan. 1960</u> and last saw <u>her</u> alive on <u>Dec. 23rd 1959</u> . Death occurred at <u>4:35</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Sidney A. Inaser</u> (Degree or title) M.D.		22b. ADDRESS <u>4901 4th Boston</u>		22c. DATE SIGNED <u>1/12/60</u>	
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		23d. LOCATION (City, town, or county) <u>Berkeley, Mo.</u>	
24. FUNERAL DIRECTOR <u>A.L. Beal Und. Co.-4303 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 14 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith. M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

4242 East

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

Arthur L. Heiliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.