

REC'D SEP 7 1939

State File No. \_\_\_\_\_

Registration District No. 225

Primary Registration District No. 5306

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Prairie Home  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) \_\_\_\_\_

8. (a) PRINT FULL NAMES GEORGE VAUGHN 150

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race colored 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Kelly Miller

(b) Address Princeton Mo.

17. (a) Splice Creek Cem. (b) Date thereof 8-14-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Splice Creek Cemetery

18. (a) Signature of funeral director Albert Hornback

(b) Address Prairie Home Mo.

19. (a) Aug 17 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Aug 9  
year 1939 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 4 1939 to Aug 12 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Chy Valvular Disease of Heart Duration 2  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions operation Right  
(Include pregnancy within 3 months of death)

Major findings: Inguinal Hernia PHYSICIAN  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature W. L. Mure deb (M. D. or other) \_\_\_\_\_  
Address Princeton Mo Date signed 8/13/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10

RECEIVED  
District Health Officer No. 8,  
License File Number  
Date Filed 9/5/39

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home Mo

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

28976

Do not use this space.

1. PLACE OF DEATH

(a) County Cooper Registration District No. 225-  
 (b) Township Saline Primary Registration District No. 2306. Registered No. 11  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth, yrs. mos. ds.

2. PRINT FULL NAME George Vaughan OVERTON MO  
 (a) Residence, No. OVERTON MO St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>about 75</u>	<u>—</u>	<u>—</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED 19.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-12 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....  
 I last saw him alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.  
 The principal cause of death and related causes of importance were as follows:  
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury..... 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify a. f. meredith, M. D.  
 (Signed) Prairie Home Mo.  
 (Address)

SUPPLEMENTARY

Local Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT DOCUMENT  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

I X12241

S-28976