SEP 28 1927

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

Do not use this space.

24088

1. PLACE OF DEATH

County: Greene — Registration District No.: 318

Township: Campbell — Primary Registration District No.: 2001

City: Springfield (No. ..... St. ..... Ward)

File No. .....

Registered No. 509

2. FULL NAME: Robert E. Taylor

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 14 1879

7. AGE: Years 48 | Months 0 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

PARENTS

10. NAME OF FATHER: Robert Taylor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kans

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Eula Taylor
(Address) 935 N. Texas Ave

15. FILED 8/18 1927 Oscar Ford MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-15 1927

17. I HEREBY CERTIFY, That I attended deceased from 8-13 1927, to 8-16 1927, that I last saw alive on 8-15 1927, and that death occurred, on the date stated above, at 2 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonitis
following Appendectomy
7/13
8/5
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Pneumonitis
(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF 8-13-1927
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. F. Greenwood, M. D
, 19 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: So Hazlewood Cem — DATE OF BURIAL: Aug 18 1927

20. UNDERTAKER: W. P. Campbell — ADDRESS: 869 Washington Ave

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.