

1928

16138-1

71-8-4

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

Do not use this space.

16138-A

1. PLACE OF DEATH

County Boone
Township Missouri
City (Name)

Registration District No. 7F
Primary Registration District No. 4046

File No.
Registered No. 07
St. Ward

2. John William Taylor 5112

(a) Residence, No. Boone Co Mo 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

White

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

single

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

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

Sept. 13 1887

7. AGE

YEARS MONTHS DAYS
22 7 6
If LESS than day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Boone Co. Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Chas. M. Taylor

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Virginia

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Johanna

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Do not know.

(STATE OR COUNTRY)

14.

INFORMANT

Richard T. Gentry
Rockport, Mo. #1

(Address)

15.

FILED

8/24 1928
W. H. Russell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

5/19 - 1928

17. I HEREBY CERTIFY That I attended deceased from March 1928 to May 19 1928 that I last saw him alive on May 15 1928 and that death occurred, on the date stated above, at 2:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Pulmonary Tuberculosis

2317

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. H. Russell, M. D.
5/20, 1928 (Address) Rockport, Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Dugor Creek

DATE OF BURIAL

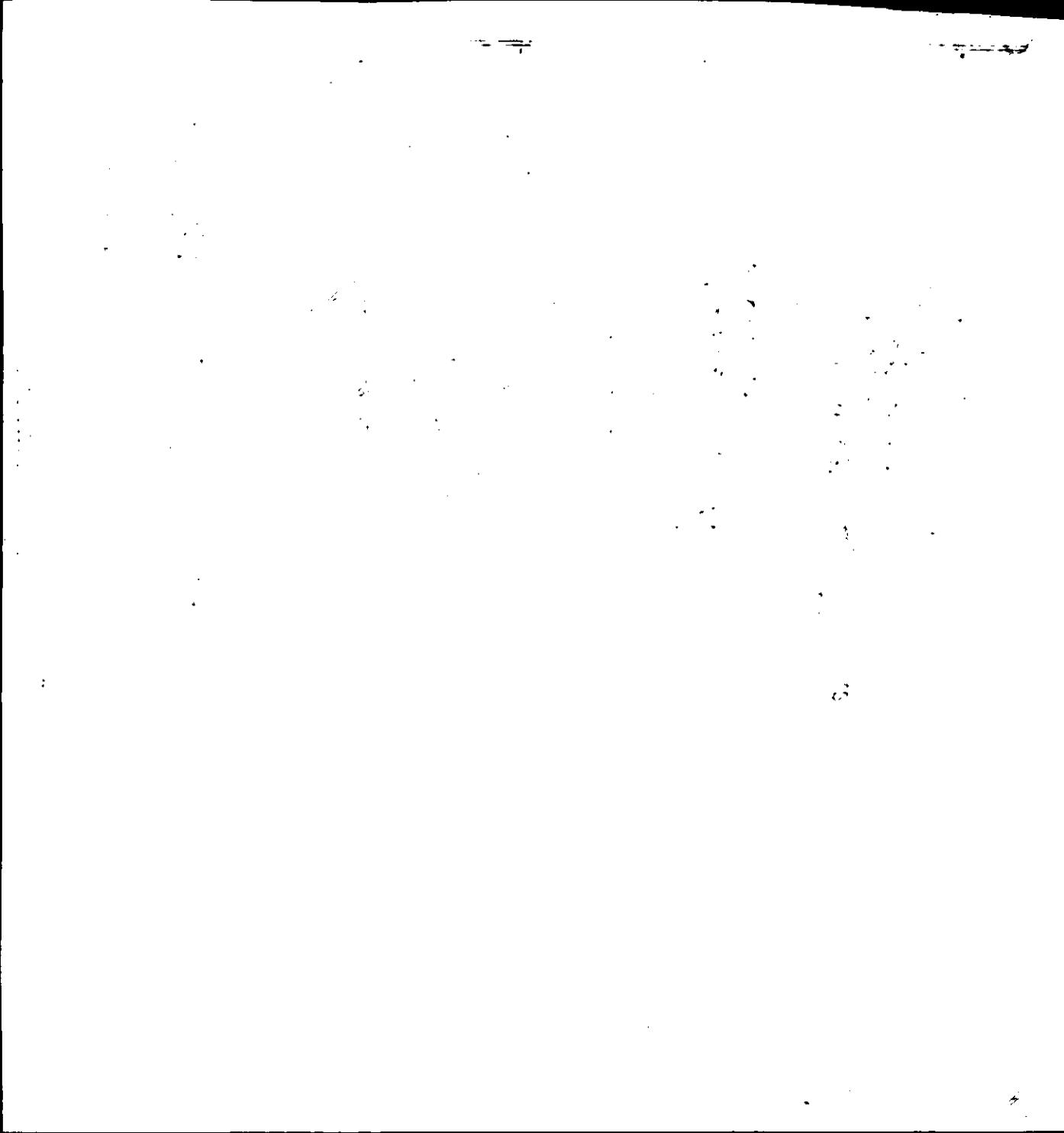
5-20-1928

20. UNDERTAKER

W. H. Vandevanter

ADDRESS

Columbiana



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

ALL INFORMATION REQUESTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Boone
 Township Missouri
 City..... (No.....)

Registration District No. 78
 Primary Registration District No. 5-113-

File No.....
 Registered No. 7
 St. Ward)

2. FULL NAME

John William 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 13, 1836

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 8 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
 (Address)

15. FILE 6/20/24 H. E. Russell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/19 1928

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

A (Signed)....., M. D.
 , 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

THEY ARE COMPLETE AS PRESCRIBED BY LAW

SHALL NOT RECEIVE A FEE FOR CERTIFICATE

SUPPLEMENTARY

