

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

Do not use this space.

31065
File No. 243
Registered No. 5 (Ward)

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Green Primary Registration District No. 3078
City Hamilton (No. 1608 Hamilton, Ind. 5 Ward)

2. FULL NAME

Samuel J. Taylor
(a) Residence. No. 1608 Hamilton, Ind. 5 Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. / How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20 1850
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 9 21
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-9-1928
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 _____.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental injuries
Probable Fracture of Skull
1868
1948 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

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

Brown Co. Ill.

10. NAME OF FATHER

John Taylor

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

Don't Know

12. MAIDEN NAME OF MOTHER

Phoebe Jagers

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

Don't Know

14.

INFORMANT Ted Taylor
(Address) Hannibal, Mo

15.

FILED 9/12/28 19____
W. E. Stone REGISTRAR

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) Chas. P. Scott Coroner
Hannibal Mo (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

Put Sleeping
Brown Co. Ill.

DATE OF BURIAL

9-12-1928

20. UNDERTAKER

James O'Donnell

ADDRESS

Hannibal, Mo

N. B. - If 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.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Marion Registration District No. 247 File No. 243
 Township Hannibal Primary Registration District No. 372-D Registered No. 3
 City Hannibal (No.) St. Ward (....)

2. FULL NAME Samuel J. 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) W

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-9-28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accident injuries
probable fractured
skull by falling from
Pear Ranch about 15 feet to
the ground.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED? 185
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Oliver R. Scott, Coroner
Marion Co Mo
 (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

SUPPLEMENTARY

14. INFORMANT (Address)

15. FILED 9/12/28 66 State REGISTRAR

N. B. - For each 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 COMPLETE AS PRESCRIBED BY LAW

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