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

Do not use this space.

9035

File No. 2789

Registered No. 2789

1. PLACE OF DEATH

County ..... Registration District No. ..... Primary Registration District No. 5107

Township ..... City St. Louis City Hospital #2 St. ..... Ward)

2. FULL NAME Ed Taylor

(a) Residence. No. 3522 St., 26 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Negro	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-16-1897

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	32	1	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(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) Kentucky

PARENTS

10. NAME OF FATHER Johnnie Taylor.

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known

14. INFORMANT Mrs. T. Woodard
(Address) City Hospital #2

15. FILED 2-1, 1929 Wm. C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 26 1929

17. I HEREBY CERTIFY, That I attended deceased from January 11 1929 to February 26 1929 that I last saw him alive on February 26 1929 and that death occurred, on the date stated above, at 2:45 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
1098
326
(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fulminating chancroid ulcer of Penis (duration) 1 yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Pathological

(Signed) J. J. Thomas M. D.

2/27 1929 (Address) City Hospital #2

*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 Washington U. DATE OF BURIAL 2/28 1929

20. UNDERTAKER W. Richter ADDRESS 3500 Pattison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

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2
2
31