

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

30475

**1. PLACE OF DEATH**

County Dunklin  
Township Salmon  
City..... (No.....).....

Registration District No. 290  
Primary Registration District No. 5408

File No.....  
Registered No. 59  
St..... Ward.....

**2. FULL NAME**

Emma 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 3 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
55 | 6 | 3

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

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

10. NAME OF FATHER Chas. Bush

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

12. MAIDEN NAME OF MOTHER " " " "

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

14. INFORMANT.....  
(Address) Sherman Taylor

15. FILED 101, 1929 H. H. R. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 5, 1929

17. I HEREBY CERTIFY, That I attended deceased from.....  
Sept. 2, 1929, to Sept. 5, 1929.  
that I last saw her..... alive on Sept. 5, 1929, and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic parenchymatous nephritis  
131  
36 (duration) 5 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Sepsis (duration) 3 mos. da.

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

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

19. WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Robert E. Maguire, M. D.  
, 19 (Address) Des Moines 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 DATE OF BURIAL  
St. Mary's Semetary Sept 6, 1929

20. UNDERTAKER  
Miss Paul [Signature] Co. Des Moines Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

35  
23  
7  
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ATTEMPT TO RECOVER THE ORIGINAL DOCUMENT  
FROM THE SOURCE OF THE INFORMATION

INVESTIGATION OF THE SOURCE OF THE  
INFORMATION IS BEING CONDUCTED  
BY THE NATIONAL SECURITY AGENCY  
AND THE DEPARTMENT OF JUSTICE

IT IS REQUESTED THAT YOU  
CONTACT THE SOURCE OF THE INFORMATION