

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

Do not use this space.

31749

PLACE OF DEATH

County.....
Township.....
City *St. Genevieve* (N.....)

Registration District No. *780*
Primary Registration District No. *4466*

File No.....
Registered No. *41* (Ward)

2. FULL NAME

Edmund 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 *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) *Jan 21/1929*

7. AGE YEARS MONTHS DAYS 10 LESS than 1 day, hrs. or min.
0 7 18

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *St. Genevieve*
(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Charles Taylor*

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

12. MAIDEN NAME OF MOTHER *Ella Wynnica*

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

14. INFORMANT *Charles Taylor*
(Address) *St. Genevieve Mo*

15. FILED *Sept 19, 1929* *T. W. Douglas* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 9 - 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 7*, 1929, to *Sept. 9*, 1929, that I last saw him alive on *Sept 8*, 1929, and that death occurred, on the date stated above, at *8:00 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Ereno-calcitis
119B
H 310
(duration) yrs. mos. *6* ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. 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*
(Signed) *R. W. Lawrence*, M. D.

9/9, 1929 (Address) *St. Genevieve 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 *St. Genevieve Mo* DATE OF BURIAL *Sept 10 1929*

20. UNDERTAKER *John Bush St. Genevieve Mo*
ADDRESS

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.

95
24-1929

