

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

Do not use this space.

34019  
4472

**1. PLACE OF DEATH**

County Jackson Registration District No. ....  
Township Law Primary Registration District No. ....  
City Laura City (No. St Joseph Hosp)

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

**2. FULL NAME**

(a) Residence No. 4427 Belle St. 7 Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. 2 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-12-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
44 8 17

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

10. NAME OF FATHER Robert M Taylor

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

12. MAIDEN NAME OF MOTHER Synthia Bray

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

14. INFORMANT Ona F Taylor  
(Address) 4427 Belle

15. FILED 10/29 29 M. Mc Crowe REGISTRAR  
asst.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-29 1929

17. I HEREBY CERTIFY, That I attended deceased from 1929 Oct. 29, 1929 that I last saw him alive on Oct. 28, 1929, and that death occurred, on the date stated above, at 12 45 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Septic meningitis  
34  
79A  
111B (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Hypostatic Pneumonia  
(Terminal) (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH Don't know

DID AN OPERATION PRECEDE DEATH? no DATE OF ..

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Blood + Spinal Exam  
ago autopsy  
(Signed) Buford H. Colby, M. D.  
10/29 29 (Address) 920 Chambers Bldg, KC. 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 Maysville Mo. DATE OF BURIAL Oct 30 1929

20. UNDERTAKER Mrs. C L Foster ADDRESS KC. Mo.

WRITE MAINLY, 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.

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72.7 Dr. Colby - Bldg  
Chambers Bldg

1-5- Haas 0147