

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

Do not use this space.

134209

1. PLACE OF DEATH

County Johnson Registration District No. 42
 Township Chilhowee Primary Registration District No. 4252
 City Chilhowee Mo (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME Rebecca E Taylor

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

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** widowed
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10-1842

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
87 I 9

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) Holden
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Wm Austin

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

12. MAIDEN NAME OF MOTHER Anna Austin

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

14. INFORMANT Susan A Taylor
 (Address) Chilhowee Mo

15. FILED _____ 19 _____
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19th 1929

17. I CERTIFY, That I attended deceased from 9-1 SEP, 1929 to Oct. 18, 1929, 19____, to Oct. 18, 1929, 19____, that I last saw her alive on Oct. Oct. 13, 1929, and that death occurred, on the date stated above, at _____ a _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
82A 102 Cerebral Apoplexy

74a (duration) _____ yrs. 1 mos. 8 ds.

CONTRIBUTORY (SECONDARY) High Blood Pressure

Dont know (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

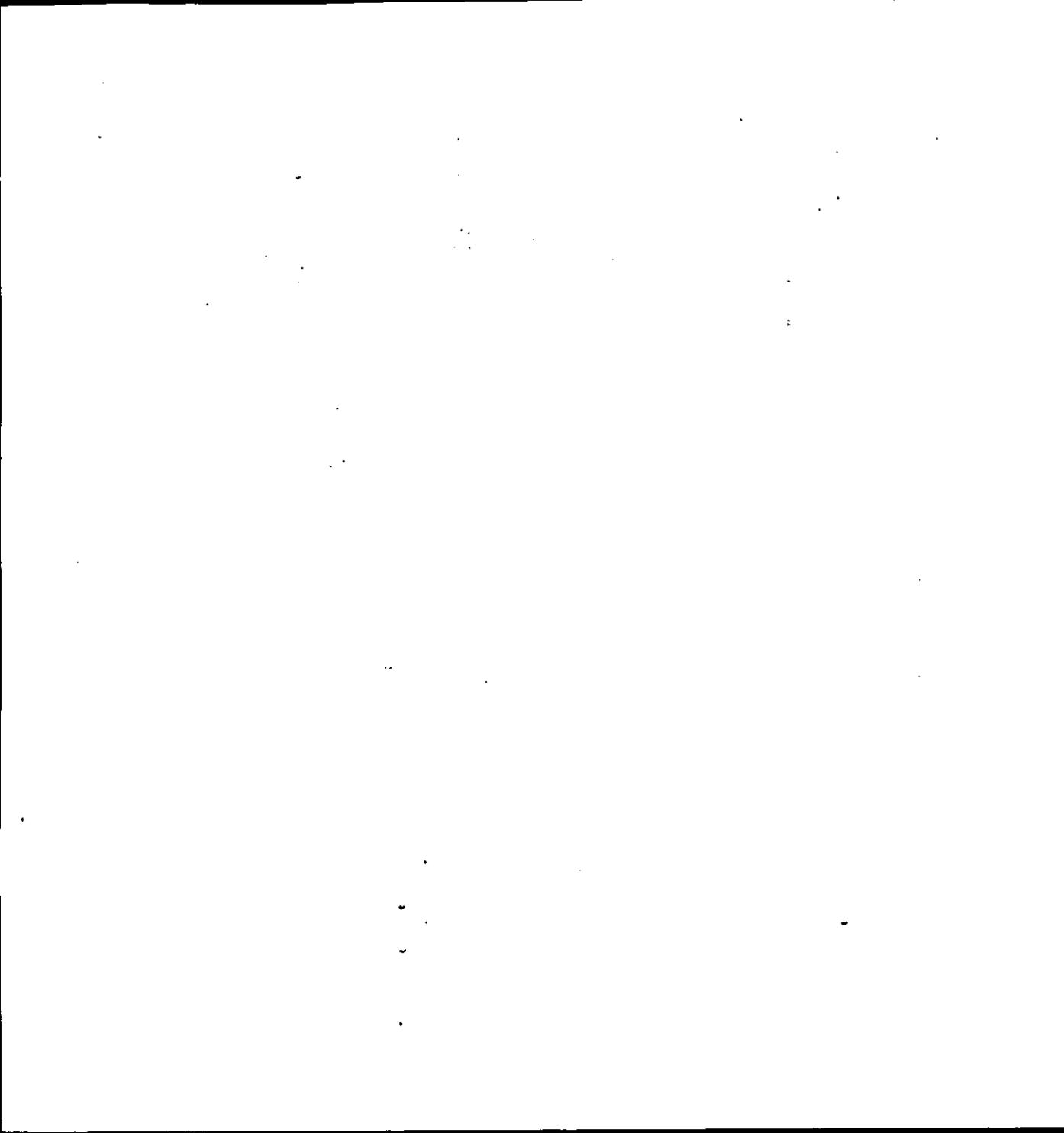
WHAT TEST CONFIRMED DIAGNOSIS characteric symptoms

(Signed) _____ M. D.
 _____ 19 _____ (Address) Magnolia,

*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 Pisgah Cemetery **DATE OF BURIAL** Oct 20-29
 19____

20. UNDERTAKER Sweeney And Cook **ADDRESS** Chilhowee



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Johnson Registration District No. 426 File No. _____
 Township _____ Primary Registration District No. 4252 Registered No. 4
 City Chilhowee (No. _____) St. _____ Ward _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10 - 1842

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
87 . 1 9

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) Holden
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Wm Austin

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

12. MAIDEN NAME OF MOTHER Anna Austin

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

14. INFORMANT Susan Taylor
 (Address) Chilhowee Mo

15. FILED 12/9, 1929 J. B. Zent
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1929

17. I HEREBY CERTIFY That I attended deceased from 9-21-1929 to Oct 12 1929
 that I last saw him alive on Oct 13 1929, and that death occurred, on the date stated above, at 8-2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) High blood pressure
Don't know (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? Characteristic symptoms
 (Signed) R. L. Bills, M. D.

, 19 (Address) Magnolia

*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 Disgah Cemetery DATE OF BURIAL Oct 20 1929

20. UNDERTAKER Sweeney and Cox ADDRESS Chilhowee

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929
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