

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

Do not use this space.

34931

**1. PLACE OF DEATH**

County St. Louis  
Township Central  
City (No. 6117) Minierwa

Registration District No. 789  
Primary Registration District No. 6093B

File No. ....  
Registered No. 310 (Ward)

**2. FULL NAME**

Isabelle Taylor  
(a) Residence. No. 6117 Minierwa St., ..... Ward. (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 Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-4-1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>58</u>	<u>5</u>	<u>1</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. School Teacher  
(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) Missouri

10. NAME OF FATHER John Taylor

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

12. MAIDEN NAME OF MOTHER Margaret Wilson

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

14. INFORMANT Adell Taylor (Address) 6117 Minierwa

15. FILED 10/16 1929 Polla Bump M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1929, to Oct 5, 1929, that I last saw her alive on Oct 5, 1929, and that death occurred, on the date stated above, at 10:45 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic interstitial nephritis

1 1/2 (duration) yrs. mos. ds. not known

CONTRIBUTORY (SECONDARY) 1 1/2 (duration) yrs. mos. ds.

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

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS urinalysis  
(Signed) W. Johnston M. D.

Oct 7, 1929 (Address) 11 N. Jefferson

\*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 Father Dickson DATE OF BURIAL 10/9 1929

20. UNDERTAKER W. Russell ADDRESS 2732 Pine

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.

96  
27  
129

2-13  
1-1  
1-1

1850

1850

1850

1850

1850

1850

1850