

APR 30 1930

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

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11339

1. PLACE OF DEATH

County Scott Registration District No. 82 File No. 25
Township Richland Primary Registration District No. 10090 Registered No. _____
City Sikeston (No. _____) St. _____ Ward _____

2. FULL NAME Margett 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. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29, 1930

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1930 to March 27, 1930
that I last saw h. alive on March 27, 1930 and that death occurred, on the date stated above, at 4 A.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March-19-1883

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 10 unk unk unk

4th Carcinoma of the Intestine

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

CONTRIBUTORY Inanition
(SECONDARY)
(duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Macroe Ark
(STATE OR COUNTRY)

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

10. NAME OF FATHER Junie Hall

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Thomas E. McClure M.D.
, 19 (Address) Sikeston Mo

12. MAIDEN NAME OF MOTHER Lonie Hall

*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.

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

14. INFORMANT J. D. Woods
(Address) Sikeston

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Sikeston Mo March 30 1930

15. FILED 3/27/30 Marta E. Denis
Sikeston REGISTRAR
minor

20. UNDERTAKER ADDRESS
L.S. William Sikeston Mo.

Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. So that it may be properly classified.

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PARENTS

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[The main body of the document is extremely faint and illegible. It appears to contain several paragraphs of text, but the characters are too light to be accurately transcribed. There are some faint markings that could be interpreted as the start of a list or a table, but they are not clear enough to identify.]

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott Registration District No. 821 File No.
Township Richland Primary Registration District No. 6070 Registered No.
City (No.) St. Ward)

2. FULL NAME

Margett 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

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

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 4/10/30 Walter Lewis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/29/30

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Carcinoma of Intestines
Primary Seat
Colon

CONTRIBUTORY (SECONDARY) Peritonitis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

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

*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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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