

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

Do not use this space.

19950

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.

Miss 237183

PLACE OF DEATH

County Lin
Township Yellow-Crest
City Dr Cothurn (No. _____)

Registration District No. 496
Primary Registration District No. 4513

File No. _____
Registered No. 47 St. _____ Ward)

2. FULL NAME Harrison Taylor

(a) Residence. No. Dr Cothurn 710 St. _____ Ward. _____

(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|----------------------------------|--|
| 3. SEX <u>Male</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED (HUSBAND OR WIFE OF) <u>Anna Taylor</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 7 - 1866</u> | | |
| 7. AGE | YEARS <u>63</u> | MONTHS <u>5</u> |
| | DAYS <u>25</u> | IF LESS than 1 day, _____ hrs. or _____ min. |

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

9. BIRTHPLACE (CITY OR TOWN) Dr Cothurn Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER William E Taylor
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER Lucretia Morris
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Belfast (STATE OR COUNTRY) Mo

14. INFORMANT Assess Taylor
(Address) Dr Cothurn Mo

15. June 3, 1930 Bessie M. Fox
DECEASED REGISTRAR
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/4/1930

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 2, 1930 that I last saw him alive on July 2, 1930, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Insufficiency
920
950
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Keptured Compensation
(duration) yrs. mos. ds. 4

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) Ed Stangler, M. D.
, 19 (Address) Brookfield 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 Rose Hill Cemetery DATE OF BURIAL 6/4/1930

20. UNDERTAKER Hunter, Rollins Brookfield Mo ADDRESS _____

