

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death to be carefully supplied.

DEC 22 1930

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

Do not use this space.

1. PLACE OF DEATH
 County Dallas Registration District No. 243
 Township Jackson Primary Registration District No. 5336
 City (No. _____) St. _____ Ward _____

2. FULL NAME Clarence Woyne 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.

File No. 35722
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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.
	<u>8</u>	<u>4</u>	<u>28</u>	

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) Dallas Com
 (STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER James Taylor
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Gerse Johnson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY) _____

14. INFORMANT Gerse Johnson
 (Address) Red Top

15. FILED 1930 _____ REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1930, to Mar 17, 1930, that I last saw him alive on Mar 17, 1930, and that death occurred, on the date stated above, at Mar 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Subar-pneumonia
10619 (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Cold (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? at home
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) W. E. Albright, M. D.
 (Address) 1616 1/2

*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 Mount Olive DATE OF BURIAL 11-18 1930
 20. UNDERTAKER L. B. Jones ADDRESS Buffalo

**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 Dallas Registration District No. 243 File No. _____
 Township Jackson Primary Registration District No. 3336 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

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

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

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

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
3 4 23

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) Dallas
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER James A Taylor

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

12. MAIDEN NAME OF MOTHER Clara Johnson

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

14. INFORMANT Jesse Johnson
 (Address) Red Top

FILED 11031 M V Rea REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 17 19 30

17. I HEREBY CERTIFY That I attended deceased from Nov 8 19 30 to Nov 17 19 30
 that I last saw him alive on Nov 17 19 30, and that death occurred, on the date stated above, at 110 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis
 (duration) yrs. mos. ds. 10
 CONTRIBUTORY Cold
 (SECONDARY) (duration) yrs. mos. ds. _____

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

DID AN OPERATION PRECEDE DEATH: no DATE OF _____

WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS:
 (Signed) W. E. Albright, M. D.

(Address) Pleasant Hope
 *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 Mount Olive DATE OF BURIAL 11/18 19 30

20. UNDERTAKER L. B. Jones ADDRESS Buffalo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 SUPPLEMENTARY

S-35702

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