

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

Do not use this space.

39352-4919

1. PLACE OF DEATH

County: Jackson Registration District No. 7002 File No. _____
 Township: Kaw Primary Registration District No. _____ Registered No. _____
 City: Kansas City (No. Sumner #2) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4 Woodlawn 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 <u>male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. Frankie Taylor</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 29, 1864</u>		
7. AGE	YEARS	MONTHS
<u>65</u>	<u>11</u>	<u>5</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) Tenn.
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>J Henry Taylor</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn.</u>
	12. MAIDEN NAME OF MOTHER <u>Eliza Bradford</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn.</u>

14. INFORMANT Reverend Class
 (Address) Sumner #2

15. FILED 12/16 1930 M. W. Crull
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1930, to Dec. 4, 1930, that I last saw him alive on Dec. 4, 1930, and that death occurred, on the date stated above, at 9:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema (Cerebral)
851
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 7401
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) D. M. Miller M. D.

Dec. 4, 1930 (Address) General Hospital No 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 Lopeska DATE OF BURIAL Dec 7 1930

20. UNDERTAKER Walter Bros ADDRESS 1729 Lyden

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.

