

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

57
Do not use this space
6174
File No. _____
Registered No. 4
St. _____ Ward)

1. PLACE OF DEATH

County Lawrence
Township Springer
City _____ (No. _____)

Registration District No. 475-
Primary Registration District No. 5639

2. FULL NAME

Alice M 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 30 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 24 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>73</u>	<u>10</u>	<u>20</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(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) Ky

10. NAME OF FATHER Louis Richie

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

12. MAIDEN NAME OF MOTHER Elizabeth Hulst

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

14. INFORMANT Allie Smith (Address) Crane m

15. FILED 2/14/1931 J. Hill Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-13-31

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1930, to Feb. 13, 1931. that I last saw him alive on Nov. 12, 1930 and that death occurred, on the date stated above, at 2:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
23A
About (duration) 6 yrs. mos. ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____ WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. Hill Smith, M. D.
2/14/1931 (Address) Wanna, 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 Marionville Mo DATE OF BURIAL 2-15-31

20. UNDERTAKER J. Hill Smith ADDRESS Crane m

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

APR 24 1931

