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.

REC'D MAR 15 1938

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

Do not use this space.

1. PLACE OF DEATH
County Gasconade
Township Canaan
City ..... (No. ..... St. ..... Ward)

Registration District No. 305
Primary Registration District No. 5422

File No. 6703
Registered No. 5

2. FULL NAME John Logan Taylor 1100
(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. 1 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 20, 1887

7. AGE YEARS 20 MONTHS 11 DAYS 18 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carrying mail
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 7 m.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bem, Mo.

FATHER
13. NAME John R. Taylor
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bem, Mo.

MOTHER
15. MAIDEN NAME Lizzie Miller
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn, Mo

17. INFORMANT (ADDRESS) John R. Taylor

18. BURIAL, CREMATION, OR REMOVAL Mo Removal
PLACE Owensville DATE Feb. 14, 1938

19. UNDERTAKER (ADDRESS) Robert Murry Owensville, Mo

20. FILED 3-4, 1938 J. J. Ferrell, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8, 1908

22. I HEREBY CERTIFY, That I attended deceased from attending, 19.. to Physician dead, 19..
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Typhoid fever	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Dr. Aufderheide Mho, M. D.
(Address) is dea at this time