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.

50M-9-19-38 I X16605

REC'D SEP 14 1939

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

27507
Do not use this space.

791

1. PLACE OF DEATH
(a) County
(b) Township
(c) or City St. Louis, Mo.
Registration District No. 1003
Primary Registration District No.
Registered No. 7007
(d) Street No. City Infirmary. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 460 Frank Taylor
(a) Residence, No. 5800 Arsenal St. St. 13
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
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) 1884.
7. AGE: 55 YEARS | MONTHS: X | DAYS: X | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. No Occupation
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee.

FATHER
13. NAME Henderson Taylor.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER
15. MAIDEN NAME Cheney Owens.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT (ADDRESS) E. Molony. 5800 Arsenal St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE City Crematory DATE 8-12-39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. Ryan City Infirmary

20. FILED AUG 12 1939 J. F. Budrek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 16, 1939, to August 10, 1939
I last saw him alive on August 10, 1939 Death is said to have occurred on the date stated above, at 12:15 p.m.
The principal cause of death and related causes of importance were as follows:
Cardiac Hypertrophy
Date of onset
Other contributory causes of importance:
Arteriosclerotic and Hypertensive Heart Disease
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) E. J. Pieri, M.D.
(Address) 5800 Arsenal

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.