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.

11

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

REC'D OCT 20 1939

31965
Do not use this space.

1049

1. PLACE OF DEATH

(a) County Buchanan 2 Registration District No. 86

(b) Township Washington Primary Registration District No. 5737 Registered No.

or

(c) City (d) Street No. Lake Contrary R.F.D. #6 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 460 Mrs. Willie R Taylor

(a) Residence, No. St. RFD #6
(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: Female
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 4 7 1890

7. AGE: YEARS 49 | MONTHS 2 | DAYS 2 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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): Danville Ky.

FATHER
13. NAME: Harry Robinson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lancaster Ky.

MOTHER
15. MAIDEN NAME: Moriah Hickmond
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lancaster Ky.

17. INFORMANT (ADDRESS): Mrs. Walter Duff RFD #6

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Ashland Cem DATE: Oct. 6th, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Ramsey's Mortuary 1602 Messanie St

20. FILED: 10/6 1939 H. Nettabush
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Oct. 3rd, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1939 to Oct 3rd, 1939
I last saw her alive on Oct 1, 1939. Death is said to have occurred on the date stated above, at 12 P.M.
The principal cause of death and related causes of importance were as follows:

Acute Bacterial endocarditis & myocarditis type bacteria not identified

Date of onset: (P)

Other contributory causes of importance: (P) 910

Name of operation: none Date of
What test confirmed diagnosis? Clinical Was there an autopsy? no

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? no
If so, specify
(Signed) H. W. Carley, M. D.
85 (Address) 301 P.S. Bldg St. Joseph Mo

(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.....J. F. Ramsey.....

Licensed Embalmer No.....4081.....

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.