

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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42146

Registration District No. 1003

Primary Registration District No.

Registrar's No. 11269

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Peoples Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 4136 Cook Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Melissa Taylor 460

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Eli Taylor 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 6th 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

73 0 24 hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 0

12. Name Unavailable, Wilson 0

13. Birthplace St. Louis Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wilson Taylor

(b) Address 4308 Maffitt Ave.

17. (a) Burial (b) Date thereof 1/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. Bates

(b) Address 4107 Finney Ave.

19. (a) DEC 31 1939 (b) _____
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30th
year 1939 hour 11:45 minutes A.M.

21. I hereby certify that I attended the deceased from December 27th, 1939, to December 30th, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 3 Days
Duration

Due to _____

Due to _____

Other conditions Diffused Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence ---

(c) Where did injury occur? ---
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ---

While at work? --- (Specify type of place) (e) Means of injury ---

23. Signature [Signature] (M. D. or other)

Address 822a N. Jefferson Date signed _____

STATEMENT BY LICENSED EMBALMER .

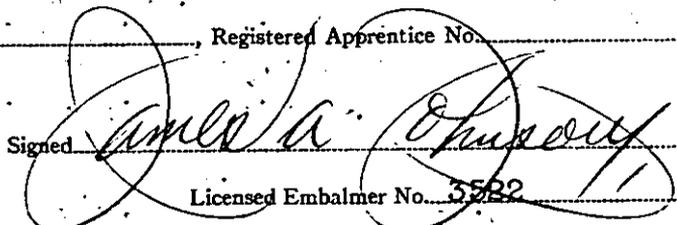
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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.