

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.

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

1698
 Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township 0 Primary Registration District No. 000
 (c) City St Joseph (d) Street No. 1002 S. 11th. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 450 AZORA MAY TAYLOR
 (a) Residence, No. 1002 S. 11th. St. (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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF O. G. Taylor.
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 14th 1877
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 11 25
 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) TULON
 (STATE OR COUNTRY) ILL.

FATHER 13. NAME Hiram Smith
 14. BIRTHPLACE (CITY OR TOWN) TULON
 (STATE OR COUNTRY) ILL.

MOTHER 15. MAIDEN NAME MARY DUGAN
 16. BIRTHPLACE (CITY OR TOWN) CHICAGO
 (STATE OR COUNTRY) ILL.

17. INFORMANT MR. O. G. Taylor
 (ADDRESS) 1002 S. 11th. St. Joseph, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Auburn DATE JAN. 11th. 1940

19. FUNERAL DIRECTOR (NAME) FLEEMAN & SON, INC.
 (ADDRESS) 1946 Calhoun St. Joseph, Mo

20. FILED Jan 16, 1940 H. J. Freestubbs
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN. 9. 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1940 to Jan 9th 1940, 1940
 I last saw h. e. a. alive on Jan 9th 1940. Death is said to have occurred on the date stated above, at 12.30 A. m.

The principal cause of death and related causes of importance were as follows:
Acute obstruction of the bowels Date of onset Jan 5 - 1940

Other contributory causes of importance:
Fracture of neck of left femur April 1937

Name of operation none Date of Jan 1940
 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? accident Date of injury 4-2-1939
 Where did injury occur? Home St Joseph Mo
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Home
 Manner of injury Fell on floor at house
 Nature of injury Fracture of femur

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____ (Signed) Herbert Beck M. D.
 (Address) King Hill Belg
St. Joseph Mo.

1782

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.....

C. G. Swan
Licensed Embalmer No. 4082

P. O. Address St. Joseph

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1698
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85.
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 31
(c) City St Joseph (d) Street No. _____
(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 Azara May Taylor

(a) Residence, No. _____ St. _____
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
62 11 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Mar. 12, 1940 H. J. Neathel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 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:

acute obstruction of the bowels - palpable strings probably maligned
Other contributory causes of importance fracture of neck of left femur

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) Leroy Beech, M. D.

(Address) King Hill, Bely
St Joseph Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CASES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

