

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.

JUL 15 1940

Registration District No. 19

Primary Registration District No. 4023

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Atchison
 (b) City or town Rural, Colby 1907
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 81 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Atchison
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Colby 1907 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 81 yrs years

3. (a) PRINT FULL NAME MRS ALICE TAYLOR
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month July day 3 year 1940 hour 10:15 minute _____ M.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife E. W. TAYLOR 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 10 13 1858 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept _____, 1938, to July 3, 1940;
 that I last saw him alive on May 15, 1940;
 and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 8 Days 21 If less than one day _____ hr. _____ min.

Immediate cause of death myocardial heart disease Duration 10 yrs

9. Birthplace ATCHISON CO MO (City, town, or county) (State or foreign country)

Due to _____
 Due to _____

10. Usual occupation HOUSE WIFE

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: Of operations _____ Of autopsy _____

12. Name JACOB HUGHES 13. Birthplace OHIO (City, town, or county) (State or foreign country)

PHYSICIAN _____ Underline the cause to which death should be charged statistically

14. Maiden name MARILYN THOMPSON 15. Birthplace DALLOWAY CO MO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jacob Gene Hughes (b) Address Rock Hill, MO

17. (a) Burial (b) Date thereof 7-5-1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freemill Cem

18. (a) Signature of funeral director James O. ... (b) Address Rock Hill, MO

19. (a) July 3 (b) Max Chamberlain (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (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? No

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

23. Signature James O. ... (M. D. or other) _____
 Address Rock Hill, MO Date signed 5-5-40

RECEIVED

District Health Officer No. 11;

District File Number

740-1197
JUL 11 1940

Date Filed

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

Ernst Benkelman

Licensed Embalmer No.

3173

P. O. Address

Rock Hill, Mo.

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.