

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23705

State File No. _____

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No. 6150

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days
(Specify whether
In this community 3-1/2 years
years, months or days)

3. (a) PRINT FULL NAME Florence Taylor 460

3. (b) If veteran, name war XXX 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Albert Taylor 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased November 9, 1903
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
-	<u>36</u>	<u>8</u>	<u>13</u>	hr. _____ min.

9. Birthplace Tiff, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At home

12. Name William Skaggs 7

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Annie Stivers

15. Birthplace XXX Arkansas 1
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Taylor
(b) Address Forder & Ringer, Lemay, Mo.

17. (a) Burial (b) Date thereof July 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Trinity Lutheran Cem.

18. (a) Signature of funeral director C. Hoffmeister & S. Co.
(b) Address 7814 S. Broadway, St. Louis, Mo.

19. (a) JUL 23 1940 (b) J. F. Bredik
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Lemay M.R.
(If outside city or town limits, write "RURAL")
(d) Street No. 0 Ringer and Forder avenues
(If rural, give location)
(e) If foreign born, how long in U. S. A.? XXX years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22,
year 1940 hour 12:45 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from July
17, 19 40 July 22, 19 40
that I last saw her alive on July 22, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death
Diabetic Acidosis
Pulmonary Tuberculosis

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

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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? _____

(Specify type of place)
While at work? _____ (e) Means of injury 1
23. Signature Harold Freedman M.D. (M. D. or other)
Address 1515 Lafayette Date signed 7/22/40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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, fact should be so stated above.