DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39509 37/17

Registration District No. 685

Primary Registration District No. 5909-13

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Pike Calvert
(b) City or town Clarksville Rural
(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 years, months or days)
In this community 24 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike
(c) City or town Clarksville Rural
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
0
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Edwin Taylor
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) ~~Single, widowed~~, married, divorced Married
6. (b) Name of ~~husband~~ or wife Lila Robinson Taylor
6. (c) Age of ~~husband~~ or wife if alive 48 years
7. Birth date of deceased Aug (Month) 12 (Day) 1877 (Year)
8. AGE: Years 63 Months 3 Days 8 If less than one day hr. min.
9. Birthplace Weatherford (City, town, or county) Tex (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Dairy Man
MOTHER FATHER
12. Name Ira B Taylor
13. Birthplace (City, town, or county) Key (State or foreign country)
14. Maiden name Mary Edwards
15. Birthplace (City, town, or county) Key. (State or foreign country)
16. (a) Informant Lila Robinson Taylor
(b) Address Clarksville
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Clarksville
18. (a) Signature of funeral director L A Brown & Son
(b) Address 124 E Brown Clarksville
19. (a) 11-30- (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20 year 1940 hour 9 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan 1, 1940, 19 to Nov 20, 1940; that I last saw him alive on Nov 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomas of face and neck — Duration 11 months
Due to Lymphosarcoma
Due to —
Other conditions (Include pregnancy within 3 months of death) —
Major findings: Of operations —
Of autopsy —

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) —
(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

23. Signature E M Bartlett (M. D. or other)
Address Clarksville Mo. Date signed 11/21/40

(Licensed Embalmer's Statement on Reverse Side)

52

RECEIVED

District Health Officer No. 10

District File Number 12-40-2267

Date Filed DEC 11 1940

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

L H Brown, Registered Apprentice No.

working under my personal supervision.

Signed L H Brown

Licensed Embalmer No. 2648

P. O. Address Clarksville

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.

. S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39509

Registration District No. 685 Primary Registration District No. 5909 13 Registrar's No. 37

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

1. PLACE OF DEATH:

(a) County Pike

(b) ~~City or town~~ Calumet T. P.
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME Wm Edw. Taylor

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 20 year 1920 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma face and ?

Duration

Due to First noticed in superficial cervical glands left side of neck. Not treated with

Due to X-ray. Afterwards it returned & and affected left side of face and neck

Other significant conditions (Include pregnancy within 3 months of death) Pure industrial multiple

Major findings: Of operation: Cancer of glands of neck

Of autopsy: 5/3 EMB

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)

(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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

1940
S-39509