

WED JAN 8 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Ramos City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **K.C. Municipal Tbc Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo 3 da**
(Specify whether years, months or days)
In this community **1 mo 3 da**

3. (a) PRINT FULL NAME **Sox Soxie Taylor**

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

4. Sex **F** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Willie Taylor** 6. (c) Age of husband or wife if alive **Unk.** years

7. Birth date of deceased **April 15 1878**
(Month) (Day) (Year)

8. AGE: Years **42** Months **7** Days **19** If less than one day hr. min.

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

10. Usual occupation **Cook**

11. Industry or business **9**

12. Name **Soloman Nispiens**

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

14. Maiden name **Ola Jackson**

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

16. (a) Informant's own signature **Hosp Records**

(b) Address **K.C. Municipal Tbc Hosp**

17. (a) **Removal** (b) Date thereof **12 6 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fulton Mo**

18. (a) Signature of funeral director **Thym + Brewster**

(b) Address **1819 E. 12th K.C. Mo**

19. (a) **12-5-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **Fulton**
(If outside city or town limits, write "RURAL")
(d) Street No. **830 W. Minster**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **5**
year **1940** hour **8** minute **35 AM.**

21. I hereby certify that I attended the deceased from **Nov 31**, 19**40**, to **Death**, 19**40**;
that I last saw her alive on **Dec 4, 1940**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Duration _____

Due to _____
Due to **23**

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? _____

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

23. Signature **Oliver T. Boyd** (M. D. or other) _____
Address **K.C. T.C. Hospital** Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Rev. 5-17-39
U.S. GPO 1935

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.

FEB 5 1945

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

Edw. E. Evans

Licensed Embalmer No.

3876

P. O. Address

1819 E 15th St
Wichita, 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.