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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41663

JAN 8 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 5056

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Gen. Hosp. #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-1-40 to 12-22-40 (Specify whether

In this community 3 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 628 Campbell (If rural, give location)

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

3. (a) PRINT FULL NAME Ronald Leroy Taylor

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

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

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

7. Birth date of deceased 9 (Month) 9 (Day) 40 (Year)

8. AGE: Years | Months 3 | Days 13 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Clayborne Taylor
13. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Margaret Lee
15. Birthplace ..... (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-41 (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm A Lohmeyer

(b) Address 18 Gen Hospt

19. (a) Dec. 31, 1940 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 22 year 1940 hour 3 minute 55 M.

21. I hereby certify that I attended the deceased from 12-1-, 1940, to 12-22-, 1940, that I last saw him alive on 12-22-, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition & Bronchopneumonia (Primary)

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration

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 G C Snow (M. D. or other)

Address ..... Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.