

S. No. 2
I-9-4-41
7-5-17-39
P-1 X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3739
State File No. _____
Registrar's No. 1272

FILED DEC 6 1943
Registration District No. _____

Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Joseph
(c) Name of hospital or institution: State Hospital #2
(d) Length of stay: In hospital or institution 3 yrs 6 mos 10 days
In this community Yes years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Charles
(c) City or town St. Joseph
(d) Street No. 2327 Market St
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Rachel Taylor
(b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH: Month 11 day 22
year 1943 hour 2 minute 55 a.m.

4. Sex Female 5. Color or race colored 6. (a) Single, widowed, married, divorced widowed
(b) Name of husband or wife deceased (c) Age of husband or wife if alive _____ years
7. Birth date of deceased not known

21. I hereby certify that I attended the deceased from Sept 1st 1943 to Nov 22 1943
that I last saw alive on Nov 21 1943
and that death occurred on the date and hour stated above
Immediate cause of death acute parenchymatous nephritis
Duration 10 days

8. AGE: Years about 45 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to not known
Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 120

10. Usual occupation Domestic

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER: 11. Industry or business _____
12. Name May Marshal
13. Birthplace Kentucky
14. Maiden name Anna Ruby
15. Birthplace St. Charles, Mo

22. If death was due to external causes, fill in the following:

16. (a) Informant State Hospital #2 records
(b) Address St. Joseph
17. (a) Burial (b) Date thereof 11-24-43
(c) Place: burial or cremation Alton Ill
18. (a) Signature of funeral director Joel Russell
(b) Address 1924 Central Ave Alton Ill
19. (a) 11-24-43 (b) Rose Alton Ill

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(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 B. E. Quinn
Address State Hosp #2 Date signed 11-23

1223

(Licensed Embalmer's Statement on Reverse Side) St Joseph, Mo 1943

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.